SERFF Tracking Number:	*ICCI-127129270*	*State:*	*California*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*PF-2011-01107*
Company Tracking Number:	*STERLING SMALL GROUP MAJOR MEDICAL PLAN*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*Sterling Small Group Major Medical Plan*		
Project Name/Number:	*Sterling Small Group Major Medical Plan/ Sterling Small Group Major Medical Plan*		

Filing at a Glance

Company: Sterling Life Insurance Company

Product Name: Sterling Small Group Major Medical Plan	SERFF Tr Num: ICCI-127129270	State: California
TOI: H16G Group Health - Major Medical	SERFF Status: Assigned	State Tr Num: PF-2011-01107
Sub-TOI: H16G.003A Small Group Only - PPO	Co Tr Num: STERLING SMALL GROUP MAJOR MEDICAL PLAN	State Status:
Filing Type: Form		Reviewer(s): Angela Jang, Marsha Seeley, Sai-on Sam, Ali Zaker-Shahrak, Wayne Thomas, Karl Whitmarsh, Shelly Huang
	Author: Brenda Dawson	Disposition Date:
	Date Submitted: 05/31/2011	Disposition Status:
Implementation Date Requested: On Approval		Implementation Date:

General Information

Project Name: Sterling Small Group Major Medical Plan	Status of Filing in Domicile:
Project Number: Sterling Small Group Major Medical Plan	Date Approved in Domicile:
Requested Filing Mode: File & Use	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 05/31/2011	
State Status Changed:	Deemer Date:
Created By: Brenda Dawson	Submitted By: Brenda Dawson

Corresponding Filing Tracking Number:
PPACA: Not PPACA-Related
PPACA Notes: null
Filing Description:
see attached filing cover sheet and forms

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*ICCI-127129270*	*State:*	*California*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*PF-2011-01107*
Company Tracking Number:	*STERLING SMALL GROUP MAJOR MEDICAL PLAN*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
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Project Name/Number:	*Sterling Small Group Major Medical Plan/ Sterling Small Group Major Medical Plan*		

Brenda Dawson, Authorized Representative
3925 East State Street, Suite 200
Rockford, IL 61108
Brendadawson@inscompliance.com
815-316-6714 [Phone]
815-986-2355 [FAX]

Filing Company Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Sterling Life Insurance Company	CoCode: 77399	State of Domicile: Illinois
2219 Rimland Drive	Group Code:	Company Type:
Bellingham, WA 98226	Group Name:	State ID Number:
(360) 647-9080 ext. [Phone]	FEIN Number: 13-1867829	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sterling Life Insurance Company	$0.00		

SERFF Tracking Number:	*ICCI-127129270*	*State:*	*California*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*PF-2011-01107*
Company Tracking Number:	*STERLING SMALL GROUP MAJOR MEDICAL PLAN*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*Sterling Small Group Major Medical Plan*		
Project Name/Number:	*Sterling Small Group Major Medical Plan/ Sterling Small Group Major Medical Plan*		

Form Schedule

Lead Form Number: SLIC SGPOL 511

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	SLIC SGPOL 511	Policy/Contract/Fraternal Certificate	Small Group Policy	Initial			SLIC SGPOL 5-11 _Group Policy_.pdf
	SLIC SG CER CA 511	Certificate	Small Group Certificate	Initial			CA SLIC SG CER 511 5-26-11.pdf
	SLIC NOTCA 511	Certificate Amendment, Insert Page, Endorsement or Rider	Notice	Initial			CA Notice.pdf
	SLIC SGSCH CA 511	Schedule Pages	Schedule of Benefits	Initial			CA SLIC SGSCH CA 511 _Schedule of Benefits_.pdf
	SLIC SGER APP CA 511	Application/Enrollment Form	Group Application	Initial			CA SLIC SGERAPP CA 511_Employer App_.pdf
	SLIC SOV SG 511	Outline of Coverage	Statement of Variability	Initial			CA Statement of Variability.pdf

STERLING LIFE INSURANCE COMPANY

[P.O. Box 5348, Bellingham, WA 98227-5348]
[(800) 688-0010]

GROUP POLICY NUMBER: [XXXXXX]

POLICYHOLDER: [XYZ Company]

DATE OF ISSUE: [December 1, 2008]

RENEWAL PREMIUMS ARE DUE MONTHLY beginning on the [1st day of January, 2009] and on the 1st day of each month thereafter, in United States Dollars only.

POLICY ANNIVERSARIES occur annually beginning [January, 2009]

STATE OF DELIVERY: [XXXX]

Sterling Life Insurance Company (hereinafter referred to as the Insurance Company, We, Our, or Us) agrees to pay the Group Insurance Benefits herein provided to each insured Employee of a Policyholder, subject to the terms and conditions of the Policy. Benefits are payable in United States Dollars only.

The Policy is issued to the Policyholder in consideration of application and payment of premiums, to take effect as of the Date of Issue. The Policy will terminate as hereinafter provided.

All periods indicated herein begin and end at 12:01 A.M. Standard Time at the address of the Policyholder.

The first premium is due on the Date of Issue and renewal premiums are due monthly during the continuance of the Policy.

The Policy is delivered in and is governed by the laws of the state of delivery.

The benefits and provisions set forth on the following pages and riders are a part of the Policy as if recited over the parties' signatures.

IN WITNESS WHEREOF, the Insurance Company has caused the Policy to be executed at its Home Office in City, State.

[ ][ ]

Secretary President

TABLE OF CONTENTS

1. SCHEDULE OF BENEFITS:

The attached Certificate of Group Insurance is incorporated into and made a part of this Policy.

The Policyholder/Employer/Plan Administrator (hereinafter referred to as "Employer") selected the following insurance benefits which are described in the attached Certificate of Group Insurance:

MAJOR MEDICAL EXPENSE INSURANCE

The insurance benefits and coverage are as selected and agreed upon between Us and the Employer. All coverages and actual benefit amounts in effect with respect to each insured Employee and his insured Dependents, if any, will be as described in the individual Certificate issued by Us to or for that Employee which will include his or her personal Schedule of Benefits.

2. DEFINITIONS

All terms are as defined in the attached Certificate of Insurance.

3. THE CONTRACT

The Policy, the application of the Employer, the Certificate and the Employees' applications, if any, shall constitute the entire contract between the parties. All statements made by the Employer or by the Employees shall be deemed representations and not warranties. No such statement, in the absence of fraud, shall be used in any contest under the Policy unless it is contained in a written instrument and a copy of the instrument is or has been furnished to the Employer or Employee.

4. INCONTESTABILITY

The validity of the Policy shall not be contested, except for non-payment of premiums by the Employer, after it has been in force for two years from its date of issue. No statement made by the Employer or any Employee, except a fraudulent misstatement, shall be used to contest the validity of any insurance with respect to which that statement was made after the insurance has been in force for two years prior to the contest and is contained in a written instrument signed by the Employee, and a copy of such instrument is or has been furnished to him or to his Employer.

5. INDIVIDUAL CERTIFICATES

We will issue to each Employer for delivery to each Employee, an individual certificate which states the essential features of the insurance to which the Employee is entitled, to whom benefits are payable, each limitation or requirement in the Policy that pertains to the Employee, and the requirements for payment of benefits.

6. POLICYHOLDER NOT INSURANCE COMPANY'S AGENT

The Employer shall not be considered the Insurance Company's agent for any purpose under the Policy.

7. ELIGIBILITY FOR INSURANCE

An Employee and/or his Dependents will be eligible for insurance as provided in Part 2 – ELIGIBILITY FOR INSURANCE in the Certificate of Group Insurance.

8. EFFECTIVE DATE OF INSURANCE

Insurance for an Employee and/or his Dependents shall be effective as provided in Part 3 - EFFECTIVE DATE OF INSURANCE in the Certificate of Group Insurance.

9. TERMINATION OF INSURANCE

Insurance for an Employer, Employee and/or his Dependents shall terminate as provided in Part 10 – RENEWABILITY AND TERMINATION in the Certificate of Group Insurance.

10. RENEWABILITY OF INSURANCE

The Policy is on a monthly renewable basis at the option of the Employer, except for the following reasons:

1. Non-payment of the required premium;
2. Fraud or intentional misrepresentation of a material fact by the Employer, or with respect to coverage of an Insured, fraud or intentional misrepresentation of a material fact by the Insured or such person's representative;
3. For failure to comply with Policy provisions, including failure to provide proof, whenever requested by Us, that the Employer is complying with the contribution and participation requirements;
4. For not maintaining Employee participation requirements for at least six consecutive months ;
5. For not maintaining Employee contribution requirements
6. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would not be in the best interests of the Policyholder or certificateholders;
7. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would impair Our ability to meet Our obligations;
8. The type of coverage under the Policy is no longer offered by Us in the state of the Employer's reisdence in which event We will provide ninety (90) days prior written notice of the discontinuance and We will offer the Employer

the option to purchase any other health insurance coverage currently being offered by Us to employers in the small group market in that state.

9. We decide to discontinue offering all health insurance in the small group market in the state of the Employer's residence in which event We will provide the applicable State authorities and the Employer written notice 180 days prior to the discontinuation and We will discontinue all health insurance issued or issued for delivery in the small group market in the state of the Employer's residence and will not renew coverage in the state of the Employer's reisidence.

All insurance under the Policy for an Employer, its Employees and their Dependents shall be non-renewed as follows:

1. Lapse due to non-payment of premium, at 12:01 A. M., of the premium due date following the end of the month for which the last premium payment is made on account of the Employer's insurance; or
2. Non-renewal for all other reasons, at 12:01 A. M., of the premium due date coinciding with or next following the date such event took place.

11. PREMIUMS

Payment Of Premium

Premiums are payable by the Employer to Us in accordance with Our then current premium rating manual. No insurance agent, insurance broker or insurance consultant is authorized to accept any premium payment on Our behalf. The Employer must timely pay the monthly premium in order to maintain the Policy. The payment of any premium will not keep the Policy in force beyond the due date of the next premium, except as provided in the Grace Period. If any premium is not received by Us before or at the end of the Grace Period, the Policy will automatically end at the end of the period for which the last premium payment has been paid.

1. We reserve the right to change the rates on any premium due by giving written notice to the Policyholder at least thirty (30) days in advance of the change.
2. If any change or clerical error affects premiums, an equitable adjustment in premiums shall be made on the premium due date next following the date of the change or the discovery of the error. Any premium adjustment that involves refund of unearned premium shall be limited to the three (3) months immediately preceding the date that We determine the adjustment in premium should be made and We will reduce that refund by the amount of benefits paid for claims incurred during the period for which the refund is made.
3. Premium due dates are the first of a calendar month. All insurance shall be charged from and to the premium due date.

Grace Period. The Employer is entitled to a grace period of 31 days for the payment of any Premium due except the first, during which grace period the Policy shall continue in force, unless the Employer has given the Company written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the Policy. The Employer shall be liable to the Company for the payment of a pro rata Premium for the time the coverage was in force during such grace period.

12. NON PARTICIPATING

The Policy does not share in the surplus earnings of the Insurance Company and no refund or assessment shall be made to the Employer or Employee of any excess or deficit earnings of the Insurance Company.

13. MISSTATEMENT OF AGE

If the age of an Insured Person has been misstated, We will make an equitable adjustment of premiums or benefits or both. We will change the benefit to the applicable amount available for the correct age. We will refund to the Employer any excess premium paid over the amount due for the correct benefit amount. We will request payment for any overdue premium for the correct benefit amount.

14. CONFORMITY WITH LAW

If any provision of the Policy is contrary to federal or state law, this Policy is hereby amended to conform thereto.

15. EMPLOYEE PARTICIPATION AND CONTRIBUTION REQUIREMENTS

The following Employee Participation and Contribution Requirements must be met and maintained at all times. Employees: Participation by a minimum of 2 Eligible Employees is required at all times, and 75% Employee participation is required at all times. No more than 50% of the total number of eligible Employees may waive insurance under the Policy by reason of having other Creditable Coverage.

If for any reason the Employer falls below any or all of the minimum number participation or minimum percentage participation requirements, the Employer has a 6 month period, beginning on the premium due date that coincides with or next follows the date the event occurs, to reestablish and continue the minimum participation requirement(s). If the minimum participation requirement(s) is (are) not continued for at least 6 consecutive months, and not

reestablished by the end of that 6 month period, all insurance under the Policy for the Employer and its Employees shall terminate.

For coverage for Eligible Employees to become and remain effective, an Eligible Employee must contribute at least 25% of the monthly premium due for Employee only insurance under the Policy.

16. EMPLOYER RESPONSIBILITIES

The Employer agrees:

1. To offer each employee the opportunity to elect group coverage under The Policy when he or she attains the status of an Employee as provided for in The Policy. It is understood that Employees are free to choose either Our Group Coverage or any other such group coverage as may be made available by the Employer. Every Employee will be given a fair opportunity to elect one of such options over the other and will not be penalized by the Employer because of such a choice.
2. To furnish Us on a monthly basis on Our-approved forms, such information as may reasonably be required by Us for the administration of the group coverage, including any change in a Insured Person's eligibility status.
3. To comply with all policies and procedures established by Us in administering and interpreting the group coverage.
4. To furnish all enrollment and termination change notifications to Us solely on Our enrollment and termination forms and within the time periods required by The Policy.
5. At reasonable times while the group coverage is in force, and for 24 months after that, We may inspect any of the Employer's documents, books, or records that may affect the claims arising from The Policy or its premiums.

17. CONSOLIDATED OMNIBUS RECONCILIATION ACT (COBRA)

If an Employer is subject to the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended (COBRA), The Policy will provide its group heath coverage as required by COBRA's laws and regulations.

We will allow COBRA continuation, however, only if:

1. A COBRA election form is signed by the qualified beneficiary within the time frames prescribed by COBRA; and
2. The Employer notifies Us in writing, of the qualified beneficiary's request to continue coverage within 31 days from the date the qualified beneficiary signed the COBRA election form.

   Any continued coverage allowed under this provision will provide only the minimum benefits for the minimum length of time as required by COBRA on the date a person covered by The Policy becomes a qualified beneficiary.

   We assume no liability for any damages resulting from an Employer's non-compliance with any COBRA requirement or regulation. Additionally, an Employer will hold Us harmless and indemnify Us against any and all taxes, fines, penalties, losses, damages, costs, expenses, and legal fees incurred by Us, except to the extent prohibited by law, for any failure on the part of the Employer to comply with COBRA requirements or its regulations.

STERLING LIFE INSURANCE COMPANY

2219 Rimland Drive

Bellingham, Washington 98226

EMPLOYER GROUP INSURANCE

CERTIFICATE OF GROUP INSURANCE

This individual Certificate is issued as evidence of the insurance provided under the Group Policy (the Policy), issued to the above Policyholder.

The insurance described herein is effective only if the individual is eligible for such insurance, premiums are paid to the Insurance Company on account of such individual and the individual becomes and remains insured as provided in the Policy. The provisions described in this Certificate are subject to all the provisions, terms and conditions of the Policy. The Policy may be amended, changed, canceled or discontinued in accordance with the provisions thereof, without the consent of the individual. This Certificate supersedes and replaces any and all other insurance certificates and riders that may have been issued to the individual insured under any and all Group Policies issued to the Policyholder by:

STERLING LIFE INSURANCE COMPANY
(Herein referred to as the Insurance Company, We, Our or Us)

[ ][ ]

SECRETARY **PRESIDENT**

When Covered Charges are incurred from an Out-of-Network Provider for Emergency Services, benefits will be paid at the In-Network benefit level shown in the Schedule of Benefits, until the Insured Person is stabilized and can be safely transported to an In-Network Provider as determined by the utilization review manager and the attending Physician. Otherwise, benefits will be reduced to the Out-of-Network Coinsurance Percentage shown in the Schedule of Benefits.

Insured Persons who have complaints regarding their ability to access needed medical care in a timely manner may complain to the Insurer and to the California Department of Insurance. The address and the customer service telephone number of the insurer are: [400 Highway 169 South, Suite 800 1-800, 847-8361]. The address and toll free telephone number of the Consumer Services Division of the Department of Insurance is: [300 South Spring Street; Los Angeles, CA 90013l 1-800-927-HELP].

The Policy will not begin to pay for Your health care expenses until after Your health care bills exceed the Deductible amount. You will have to pay for all of Your health care bills until these bills exceed Your Deductible amount.

The provisions and benefits described herein may be different from any and all group insurance coverage You may have or have had. Please read this Certificate carefully.

CERTIFICATE FACE PAGE

Certificate Issued To: «Insured_Name»

Herein Called the Employee and to Insured Dependents:

«Dependent_1»	«Dependent_2»
«Dependent_3»	«Dependent_4»
«Dependent_5»	«Dependent_6»
«Dependent_7»	«Dependent_8»
«Dependent_9»	«Dependent_10»
«Dependent_11»	«Dependent_12»

Effective Date of Insured: «Insured_Effective_Date»

Policy Number: «Policy»

Policyholder, Employer and Plan Administrator: «The ABC Company»

Employer Effective Date: «Employer_Effective_Date»

COVERAGE ISSUED: «Coverages»

NOTICE OF PRE-EXISTING CONDITION LIMITATION

Coverage under the Policy is subject to a pre-existing condition limitation until the following date:

Name	Date	Name	Date
«Insured_Name»	«InsuredPXT»	«Dependent_1»	«D1PXT»
«Dependent_2»	«D2PXT»	«Dependent_3»	«D3PXT»
«Dependent_4»	«D4PXT»	«Dependent_5»	«D5PXT»
«Dependent_6»	«D6PXT»	«Dependent_7»	«D7PXT»
«Dependent_8»	«D8PXT»	«Dependent_9»	«D9PXT»
«Dependent_10»	«D10PXT»	«Dependent_11»	«D11PXT»
«Dependent_12»	«D12PXT»		

If You believe that You and/or Your dependents should not be subject to a pre-existing condition limitation or that the pre-existing limitation should be for a shorter period of time, You and/or Your dependents may request a certificate from a prior plan or issuer that demonstrates prior creditable coverage.

Certificate Index

PART 1 – DEFINITIONS

ACCIDENT/ACCIDENTAL means any sudden or unforeseen event which:

1. causes harm to the physical structure of the body;
2. results from an external agent or trauma;
3. is definite as to time and place; and
4. happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.

ACUPUNCTURE means the insertion of needles into the human body by piercing the skin of the body, for the purpose of controlling and regulating the flow and balance of energy in the body to assist in rehabilitation and restoration of previously existing normal bodily functions which were lost or compromised after Injury or Sickness, but only if such treatment results in measurable improvement and is provided by a Physician or licensed acupuncturist.

AGGREGATE FAMILY DEDUCTIBLE means that under a family plan, there is only one Deductible (Family Deductible) where each family member's covered medical expenses are combined to meet the Family Deductible.

AGGREGATE FAMILY OUT-OF-POCKET MAMIMUM means that under a family plan, there is only one Out-Of-Pocket Limit (Family Out-of-pocket) where each family member's covered medical expenses are combined to meet the Family Out-of-Pocket Maximum.

ALCOHOLISM means a chronic disorder or illness in which the Insured Person is unable, for psychological or physical reasons, or both, to refrain from the frequent consumption of alcohol in quantities sufficient to produce intoxication and, ultimately, injury to health and effective functioning.

AMBULANCE means a vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care. Air ambulance charges are payable only for transportation from the site of an Emergency to the nearest available Hospital that is equipped to treat the condition instead of local Ambulance service.

AMBULATORY SURGICAL CENTER means any public or private establishment: a) with an organized medical staff of Physicians; b) with permanent facilities that are equipped and operated primarily for performing surgical procedures; c) with continuous Physician services and registered professional nursing services whenever a patient is in the facility; d) which does not provide services or other accommodations for patients to stay overnight; and e) is duly licensed as an Ambulatory Surgical Center by the appropriate state authorities.

BENEFIT RIDER means an amendment or endorsement adding a specific Benefit to the Policy, which is attached to this Certificate.

CALENDAR YEAR if shown on the Schedule of Benefits means the period of time which begins on January 1st and ends on the following December 31st. When a person first becomes an Insured Person, the first Calendar Year begins on the Effective Date of coverage and ends the following December 31st.

CERTIFICATE/CERTIFICATE OF INSURANCE means the summary of the Master Group Policy which constitutes evidence of Your coverage under the Policy.

CHEMICAL DEPENDENCY means the abuse of or psychological or physical dependency on or addiction to a controlled substance.

COINSURANCE/COINSURANCE PERCENTAGE means the Insured Person's share of Covered Charges under the Policy after any applicable [Copays and] Deductibles are satisfied and before the Coinsurance Limit is reached. The Coinsurance Percentage is shown in the Schedule of Benefits.

COINSURANCE LIMIT means the maximum amount of Covered Charges an Insured Person will pay in a Year, after any applicable [Copays and the] Deductibles are satisfied and before the Maximum Benefit or other plan maximums are reached. The Coinsurance Limit is shown in the Schedule of Benefits. After the Coinsurance Limit is reached, We will pay the remainder of the Covered Charges incurred by that Insured Person during the rest of that Year.

A higher Coinsurance Limit, as shown in the Schedule, may apply when Out-of-Network Providers are utilized.

COMPLICATIONS OF PREGNANCY (which are considered to be a Sickness under the Policy) means: a) conditions whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and b) puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, toxemia, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible, but shall not mean false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum, and other similar conditions associated with the management of a difficult pregnancy.

COPAY means the amount required to be paid by an Insured Person each time a specific service is provided, as set forth in the Schedule of Benefits and the Policy. In some instances, more than one Copay may be required. Services requiring Copays and Copay amounts are shown in the Schedule of Benefits.

COSMETIC SURGERY means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance or self-esteem.

COVERED CHARGES means charges incurred as a result of an Injury or Sickness by or on behalf of an Insured Person while the Policy is in force with respect to such Insured Person and which:

1. are Medically Necessary for the treatment of an Injury or Sickness and which have been recommended and prescribed by a Physician;
2. are not in excess of Reasonable and Customary Charges, Fees and Expenses made for the services performed or supplies furnished, or are not in excess of such Charges as would have been made in the absence of this insurance;
3. are not excluded from coverage by the terms of the Policy; and
4. do not exceed any amounts payable under the terms of the Policy.

CREDITABLE COVERAGE means with respect to an individual coverage of the individual provided under any of the following:

1. any individual or group contract, policy, certificate or program that is written or administered by a health care service plan, health insurer, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. This includes continuation or conversion coverage;
2. Part A or Part B of Title XVIII of the federal Social Security Act
3. Title XIX of the federal Social Security Actother than coverage consisting solely of benefits under Section 1928 of that act;
4. Chapter 55 of Title 10 of the United States Code (CHAMPUS);
5. a medical care program of the Indian Health Service or of a tribal organization;
6. a state health benefits risk pool;
7. a health plan offered under Chapter 89 of Title 5 of the United States Code (Federal Employees Health Benefits Program);
8. a public health plan as defined in federal regulations authorized by Section 2701 (c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996; or
9. a health benefit plan under Section 5(e) of the federal Peace Corps Act (Section 2504(e)of Title 22 of the United States Code;
10. any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital and surgical care.
11. any other Creditable Coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. § 300gg(c)).

Creditable Coverage does not include:

1. Coverage issued as a supplement to liability insurance;
2. Liability insurance including general liability insurance and automobile liability insurance;
3. worker's compensation or similar insurance
4. credit-only insurance
5. coverage for onsite medical clinics.
6. other similar insurance coverage specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Creditable coverage does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan.

1. limited scope dental or vision benefits.
2. benefit for long term care, nursing home care, home health care community based care or any combination thereof;
3. other similar, limited benefits are specified in federal regulations.

Creditable coverage does not include the following benefits if offered as independent, noncoordinated benefits:

1. coverage only for a specified disease or illness;
2. hospital indemnity or other fixed indemnity insurance.

Creditable coverage does not include the following if offered as separate insurance policy, certificate or contract of insurance:

1. Medicare supplemental health insurance, as defined by Section 1882(g)(1) of the federal Social Security Act,
2. coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code, and
3. similar supplemental coverage provided under a group health plan.

CUSTODIAL OR CONVALESCENCE CARE means any care that is provided to an Insured Person who is disabled and needs help to support the essential activities of daily living when the Insured Person is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of daily living on his own.

DEDUCTIBLE means the amount of applicable Covered Charges [other than Copays], that must be incurred by an Insured Person in any Year before benefits will be payable under the Policy. A higher Deductible amount may apply when Out-of-Network Providers are utilized for non-Emergency care. The Deductible is shown in the Schedule of Benefits or on an amendment to this Certificate.

DEPENDENT/ELIGIBLE DEPENDENT [(Grandfathered)][(Non-Grandfathered)] means an Employee's:

1. spouse, who is not legally separated or divorced from the Employee and is not a member of the armed forces;
2. child, including any step child, or legally adopted child, who has not reached the Dependent limiting age specified in the Schedule of Benefits, and living in Your home; or
3. child, including any step child, or legally adopted child, who has not reached the student limiting age specified in the Schedule of Benefits, provided however, that the child is dependent upon the Employee for support and maintenance and a full-time student actively attending an accredited college, vocational or high school. Full-time, will be determined according to the standards of the accredited college or university being attended by the Dependent.
4. Dependent is at least 50% dependent on the Employee for support and maintenance and is not eligible as an Employee. A grandchild will be considered a Dependent if the Employee has legal guardianship of the child, the grandchild is primarily (at least 50%) dependent on the Employee and appears as a Dependent on the Employee's federal tax return;
5. Domestic Partner;
6. Domestic Partner's child is covered on the same basis as an Employee's stepchild.

A Dependent spouse or Dependent Domestic Partner who also is an eligible Employee may be insured as either an Employee or Dependent but not as both.

DOMESTIC PARTNER means an adult who has chosen to share their life with an Employee in an intimate and committed relationship of mutual caring. The domestic partnership must be established in California by the filing of a Declaration of Domestic Partnership with the Secretary of State and, at the time of filing.

All of the following requirements must be met:

1. Both persons have a common residence.
2. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
3. The two persons are not related by blood in a way that would prevent them from being married to each other in California.
4. Both persons are at least 18 years of age.
5. Either of the following:
   a) Both persons are members of the same sex.
   b) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42

U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.

6. Both persons are capable of consenting to the domestic partnership.

The forms entitled "Declaration of Domestic Partnership" and "Notice of Termination of Domestic Partnership" must be available to the public at the office of the California Secretary of State and each county clerk.

Any references herein to spouse and marriage include domestic partners and domestic partnerships.

DURABLE MEDICAL EQUIPMENT means equipment that is:

1. able to withstand repeated use;
2. primarily and customarily used to serve a medical purpose;
3. not generally useful to a person in the absence of Injury or Sickness; and
4. prescribed by a Physician and Medically Necessary.

ELIGIBLE EMPLOYEE means an Employee who works [the required number of hours as defined by the Master Application] [on a full-time basis as defined by the Master Application] The term does not include an Employee who:

[1.] [works on a part-time, temporary, seasonal, or substitute basis;]

[2.] is covered under:

- A. another health benefit plan; or
- B. a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or

[3.] elects not to be covered under the Employer's health benefit plan and is covered under:

- A. the Medicaid program;
- B. another federal program, including the CHAMPUS program or Medicare program; or
- C. a benefit plan established in another country.

An Employee also is a [Retiree] [tribal member] [officer][partner][or [director] as designated by the Employer in the Master application and approved by Us.

[EMBEDDED FAMILY DEDUCTIBLE means your plan contains two provisions, an Individual Deductible and a Family Deductible. This allows each family member to receive medical expenses covered at the earlier of the Individual's satisfaction of the Individual Deductible (for that individual only), or collectively when the all Family member's combined Deductible satisfy the Family Deductible (for all family members).

[EMBEDDED FAMILY OUT-OF-POCKET MAXIMUM means your plan contains two provisions, an Individual Out-of-Pocket and a Family Out-of-Pocket Maximum. This allows each family member to receive medical expenses covered at the earlier of the Individual's satisfaction of the Individual Deductible (for that individual only), or collectively when all Family member's combined Out-of-Pocket Maximum satisfy the Family Out-of-Pocket Maximum (for all family members).

EMERGENCY ADMISSION means an admission of an Insured Person who experiences an Emergency Medical Condition resulting from an Injury or Sickness.

EMERGENCY MEDICAL CONDITION means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medication attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES With respect to an Emergency Medical Condition, Emergency Services means a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital.

EMPLOYEE means an individual employed by an Employer.

EMPLOYER means a sole proprietorship, partnership or corporation who employed an average of at least 2 but less than 51 Eligible Employees on business days during the preceding Year and who employs at least two Employees on the first day of the plan year and who is actively pursuing business interests and has applied for the Policy in connection with its own employee welfare benefit plan. An Employer must complete an Employer Application agreeing to all the terms specified by Us and meet all other requirements in the state of the Employer's residence. The Employer is deemed the Plan Administrator for the purposes of compliance with and duties arising under the Employee Retirement Income Security Act ("ERISA") and Consolidated Omnibus Budget Reconciliation Act ("COBRA").

EMPLOYER'S EFFECTIVE DATE means the Effective Date of coverage for Your Employer.

ENROLLMENT DATE means the date an Employee or Dependent enrolls under the Policy or, if earlier, the first day of any Service Waiting Period that must be satisfied before coverage becomes effective.

ENROLLMENT FORM means the form designated by Us that an Employee must complete and submit in order to request enrollment in the Policy. Enrollment Forms are available from Your Employer and must be submitted to Your Employer to be forwarded to Us.

[ESSENTIAL HEALTH BENEFITS has the same meaning as found in section 1302(b) of the federal health care reform's Patient Protection and Affordable Care Act including any amendments, regulations, rules or other guidance issues with respect to the Act.]

EXPERIMENTAL means a service for which one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. We will determine if this item 2. is true based on:
   A. Published reports in authoritative medical literature; and
   B. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health and the FDA.
3. In the case of a drug, a device or other supply that is subject to FDA approval:
   A. It does not have FDA approval; or
   B. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:
      1) included in substantially accepted peer-reviewed medical literature such as: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
      2) included in a prescription drug reference compendium; or
      3) in addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.
4. The Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to the board's approval.
5. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5 applies for protocols used by the Insured Person's Provider as well as for protocols used by other Providers studying substantially the same service or supply.

GEOGRAPHIC AREA means the first three digits of the zip code in which the service, treatment, procedure, drugs or supplies are provided, or a greater area if necessary, to obtain a representative cross-section of charges for a like treatment, service, procedure, device, drug or supply.

HEALTH BENEFIT PLAN means any Hospital or medical policy or certificate, Hospital or medical service plan contract, or health maintenance organization subscriber contract.

HOME HEALTH CARE AGENCY means a business that provides home health service under a Home Health Care Plan.

HOME HEALTH CARE PLAN means a program for continued care and treatment of an individual established and approved in writing by the individual's attending Physician. An attending Physician must certify that proper treatment of

the Bodily Injury or Sickness would require confinement in a Hospital or a Skilled Nursing Facility in the absence of the services and supplies provided as a part of a treatment plan for Home Health Care.

HOSPICE means a facility that:

1. is licensed, accredited or approved by the proper authority to provide a Hospice Care Program;
2. admits individuals who:
   A. have no reasonable prospect of cure; and
   B. have a life expectancy of six (6) months or less; and
3. provides care by a Hospice Team coordinating its services with the patient's attending Physician and the patient's Family.

HOSPICE CARE PROGRAM means a coordinated program for meeting the needs of dying individuals and their families by providing medical, nursing and other health services during the Sickness and bereavement.

HOSPICE TEAM means a group of persons composed of a Hospice Physician, a patient care coordinator (a Physician or licensed graduate registered nurse (RN)), a licensed graduate registered nurse (RN), a mental health specialist, a social worker, a Chaplain and a lay volunteer.

HOSPITAL means a legally constituted and licensed institution with organized facilities for the care and treatment of sick and injured persons on an Inpatient basis. This includes facilities for diagnosis and surgery under the supervision of a staff of one or more Physicians that provides 24 hour nursing service by licensed graduate registered nurses (RNs) on duty or call. It does not mean Custodial, Convalescent, nursing, rest or Extended Care facilities. For the purpose of Severe Mental Illness and Mental, Emotional, Nervous and Chemical Dependency Disorders only, Hospital includes an acute psychiatric Hospital as defined in subdivision (b) of Section 1250 of the California Health and Safety Code, a psychiatric health facility as defined by Section 1250.2 of the California Health and Safety Code operating pursuant to licensure by the State Department of Mental Health and a facility licensed to provide alcoholism or chemical dependency services under Chapter 2 (commencing with Section 1250 of Division 2 of the California Health and Safety Code).

IMMEDIATE FAMILY means (step) brothers, (step) sisters, (step) children, (step) parents, aunts, uncles and legal spouses.

INITIAL ENROLLMENT PERIOD means the period of time during which an Employee or Dependent is first eligible to enroll under the Policy.

INJECTABLE AND SPECIALTY MEDICATION means those covered drugs that are administered in an Insured Person's home intravenously, intramuscularly, or subcutaneously, or are used as immunosuppressant agents in organ transplant patients.

INJURY means physical harm or damage caused by an Accident. The Injury must be the direct cause of the loss, independent of disease, bodily infirmity, or any other causes. Any loss due to Injury must begin while the Insured Person's coverage is in force.

IN-NETWORK means those Covered Charges received from a Preferred Provider.

INPATIENT means an Insured Person confined and assigned to a Hospital bed for a period of twenty-three (23) consecutive hours or longer upon the advice of a Physician for other than Custodial or Convalescent Care.

INSURED PERSON/INSURED means the Employee named in the Schedule of Benefits and any Covered Dependents whose coverage with Us is in effect and has not terminated.

INTENSIVE CARE UNIT means that part of a Hospital specifically designed as an Intensive Care Unit. It is permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other Hospital rooms or wards. This care includes close observation by trained and qualified personnel primarily assigned to this part of the Hospital. This term shall not include Intermediate Care or Stepdown Units.

LATE ENROLLEE means an Employee or Dependent who does not submit an Enrollment Form during the Initial Enrollment Period and who does not qualify for a Special Enrollment Period when the Enrollment Form is submitted.

LIFE-THREATENING means a condition which, if not immediately interrupted by medical treatment, has a high likelihood of: (1) death, if the end point of the medical treatment is survival; or (2) causing major irreversible morbidity (including: loss of arm, leg, hand or foot; loss of sight or hearing; paralysis; or loss of brain function), if the end point of the medical treatment is survival and/or avoiding that morbidity. The attending Physician must verify the condition to be life-threatening.

MEDICALLY NECESSARY means services or supplies that are:

1. Required to identify or treat an Insured Person's diagnosis, symptoms, Sickness, Injury or disease;
2. In accordance with recognized standards of medical care as depicted by:
   A. use in the state where the Insured Person resides or use throughout the United States; or
   B. scientific or medical evidence accepted by a majority of the medical specialty involved.
3. Classified, recognized or acknowledged by a governmental agency as proven, safe, effective, and not Investigational, Experimental and/or for Research;
4. not in excess, in scope of duration or intensity, of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment;
5. Not solely for:
   A. the convenience of the Insured Person, the Insured Person's family, or Provider;
   B. educational purposes; and
   C. Investigational, Experimental and/or for Research, or cosmetic purposes.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII, Social Security Amendments of 1965, as amended.

MENTAL HEALTH CONDITIONS mean Mental or Nervous Disorders, Severe Mental Illness or Serious Emotional Disturbances of a Child,

MENTAL OR NERVOUS DISORDER means any nervous, emotional and mental disease, illness, syndrome, or dysfunction classified in the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* on the date care or medical treatment is rendered. This includes, but is not limited to neurosis, psychoneurosis, psychopathy, psychosis, and eating or panic disorder except for mental retardation. It also includes any nervous, emotional or mental disease caused by an organic condition, disease, illness, or syndrome, including organic mental syndrome associated with psychoactive substances (e.g., alcohol, cocaine, opiate, and others). It does not include Severe Mental Illness or Serious Emotional Disturbances of a Child.

NEGOTIATED RATE means the rate mutually agreed upon between Us and a Provider in a specific instance.

OCCUPATIONAL THERAPY means treatment of disease by physical agents and methods to assist in rehabilitation and restoration, of previously existing normal bodily functions which were lost or compromised after Injury or Sickness, through a program designed to improve endurance, strength, exercise tolerance, and performance of activities of daily living (ADL), but only if such treatment results in measurable improvement and is provided by a Physician or licensed or registered occupational therapist (O.T.R.). Maintenance therapy or other treatment provided on a routine basis as part of a standard program, and educational training or services designed and adapted to develop a physical function, are not included.

ORTHOPEDIC MANIPULATION means treatment by a Physician for physical therapy or manipulation involving the spine or any joint to assist in rehabilitation and restoration of previously existing normal bodily functions which were lost or compromised after Injury or Sickness, but only if such treatment results in measurable improvement and is provided by a Physician. This includes traction; inversion therapy; hot or cold packs; electrical stimulation therapy; vasopneumatic devices; diathermy; therapeutic exercise; neuromuscular reeducation; gait training; massage therapy; thermography; biofeedback therapy; hydrocollator therapy; passive motion therapy; acupressure; office visits and consultations.

OUT-OF-NETWORK PROVIDER means any Physician, Hospital or other health care Provider who is not a member of a PPO network contracted with Us to provide medical services to Our Insureds.

OUTPATIENT HOSPITAL EXPENSES means Covered Charges incurred by an Insured Person that are not on an Inpatient basis.

PHYSICIAN means a person who has successfully completed the prescribed course of studies in medicine at an officially recognized medical school and has acquired the requisite qualifications for licensure in the practice of medicine. The person must be a legally qualified, licensed practitioner who provides care within the scope of his/her license, and who is

not a member of the Insured Person's Immediate Family. An Insured Person will not be considered a Physician for care or treatment rendered to his/herself or his/her Immediate Family.

PHYSICIAN OFFICE VISIT means a direct personal contact between a Physician or other health care practitioner and an Insured Person in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code.

PLAN YEAR if shown on the Schedule of Benefits means the period of time which begins immediately on the Employer's Effective Date and ends each 12 months following the initial Effective Date. When a person first becomes an Insured Person, the first Plan Year begins on the Insured Person's Effective Date and ends on the next following Employer's anniversary date.

POLICYHOLDER OR GROUP POLICYHOLDER means the Employer identified as the Policyholder in the Schedule of Benefits.

PRE-AUTHORIZATION means a screening process using established medical criteria to determine whether the proposed treatment plan is appropriate. It may include proposing alternative treatment plans, concurrent length of stay reviews, and discharge planning.

PRE-EXISTING CONDITION means any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months immediately preceding the Enrollment Date; except that We will not treat genetic information or Pregnancy as a Pre-Existing Condition.

PREFERRED PROVIDER/IN-NETWORK PROVIDER means a Physician, Hospital or other health care Provider that is currently a member of a Preferred Provider Organization (PPO) network contracted with Us to provide medical services to Our Insureds. The PPO network is named on the ID card. We will provide access to a directory listing In-Network Preferred Providers. You should, however, always check to be sure a listed Provider is still a participating member of the PPO network at the time medical services are needed. A toll-free number is provided on Your ID card to locate Preferred Providers.

PREGNANCY means the period following the receipt by an Employee, Dependent spouse or Dependent child of a diagnosis of Pregnancy until the discharge of the Employee, Dependent spouse or Dependent child from the Hospital or other Facility following the delivery of the newborn child. Pregnancy does not include voluntary abortion except where the Employee, Dependent spouse or Dependent child has a Life-Threatening condition.

PRESCRIPTION DRUG/PRESCRIPTION MEDICATION means any medical substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound, which can only be dispensed pursuant to a prescription and which is required to bear the following statement on the label: "Caution: Federal law prohibits dispensing without a prescription."

PREVENTIVE CARE SERVICES means the evaluation and management of an Insured Person including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction and the ordering of appropriate immunization(s) and laboratory/diagnostic procedures – when no symptoms exist and there is no diagnosis of a Sickness.

PROVIDER means a Physician, Hospital, or any other duly licensed institution or duly licensed individual providing medical or health services.

REASONABLE AND CUSTOMARY CHARGES means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the Geographic Area in which the charge is incurred, so long as those charges are reasonable. The "most common charge" means the lesser of:

1. the actual amount charged by the Provider;
2. the negotiated rate;
3. the charge which would have been made by the Provider (Physician, Hospital, etc.) in the absence of insurance;
4. the charge which would have been made by the Provider for a comparable service or supply; or
5. the charge by other Providers in the same Geographic Area, as reasonably determined by Us, for the same or comparable service or supply.

In determining whether a charge is reasonable, We may consider other factors, including but not limited to:

1. the complexity of service or supply involved;
2. the degree of professional skill, experience and training required for a Physician to perform the procedure or service;
3. the severity or nature of the Injury or Sickness being treated;
4. the Provider's adherence or failure to adhere to charging and practices generally accepted by an established United States medical society as determined by Us;
5. the cost to the Provider of providing the service or supplies, or performing the procedure; or
6. if the information above is not sufficient to determine whether a charge is reasonable for a Geographic Area, We may refer to National Data Bases reflecting Provider fee data.

REHABILITATION FACILITY means a legally operating institution or distinct part of an institution which is primarily engaged in providing comprehensive, multidisciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care, is duly licensed by the appropriate government agency to provide such services and is accredited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation on Rehabilitation Facilities. It does not include institutions that provide only minimal care, Custodial Care, ambulatory or part-time care services.

REHABILITATIVE SERVICES means treatment, services and supplies for the purpose of restoring bodily function, which has been lost due to either an Injury or Sickness. Care ceases to be Rehabilitative Services when either (i) the Insured Person can perform the activities which are normal for the same age and gender; or (ii) the Insured Person has reached the maximum therapeutic benefit and further Rehabilitative Services cannot restore further bodily function beyond the level the Insured Person currently possesses.

RESPITE CARE means short-term care given to a Hospice patient by another care-giver so that the patient's care-giver can rest or take time off.

RETIREE means any former Employee who is covered under a non-discriminatory, written retirement plan of the Employer that provides for benefits on the same terms and conditions as an Employee.

ROBOTIC ASSISTED SURGERY means technology by which the surgeon views the operative field via a terminal from cameras inserted into the body and manipulates robotic surgical instruments via a control panel.

SERIOUS EMOTIONAL DISTURBANCES OF A CHILD means one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders other than a primary Substance Use Disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and that meet one or more of the following criteria:

a. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occurs:
   1) The child is at risk of removal from home or has already been removed from the home.
   2) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
c. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

SEVERE MENTAL ILLNESS means schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorder, panic disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

Severe Mental Illness does not include Mental or Nervous Disorder.

SERVICE WAITING PERIOD means a period of time that must pass with respect to an Employee before the Employee is eligible to be covered for benefits under the terms of the Group Policy. The Service Waiting Period is determined by the Employer on its application for coverage under the Group Policy.

SICKNESS means an illness, disease, Pregnancy, Complications of Pregnancy, Mental Health Condition or Substance Use Disorder that causes loss while an Insured Person's coverage is in force under the Policy.

SKILLED NURSING FACILITY means a place that meets all these requirements:

1. it operates within the law;
2. it provides for the care and treatment of persons recovering from an Injury or Sickness;
3. it provides room, board, and skilled nursing services;
4. it operates under the supervision of a Physician;
5. it has 24-hour nursing service which is under the supervision of a registered nurse (RN) who is on site at all times; and
6. it keeps a daily record of medical care provided to each patient.

It does not mean a rest home, a home for the aged, or a place operated primarily to provide Custodial Care.

SOUND NATURAL TEETH means teeth which are intact with a root, pulp, and have a maximum of two surfaces restored and/or decayed, and no missing tooth structure due to fracture.

SUBSTANCE USE DISORDER means Alcoholism or Chemical Dependency.

TRANSPLANT NETWORK means a health services organization, designated as a Transplant Network by the Company, which has entered into an agreement with, or on behalf of, the Company, to render Medically Necessary and medically appropriate specialty services. A Transplant Network may or may not be located within an Insured Person's Geographic Area. Services provided through a Transplant Network are coordinated by the Company.

US, WE, OUR or COMPANY means Sterling Life Insurance Company.

YEAR/YEARLY means Calendar Year or Plan Year, as shown on the Schedule of Benefits.

YOU, YOUR, YOURS means the Employee named in the Schedule of Benefits whose coverage has become effective with Us and has not terminated.

PART 2 – ELIGIBILITY FOR INSURANCE

ELIGIBILITY FOR INSURANCE
To be eligible for coverage under the Group Policy, an individual must either meet the definition of Eligible Employee or meet the definition of Dependent.

EMPLOYEE ENROLLMENT ELIGIBILITY
To become an Eligible Employee, You must:

1. Be an Eligible Employee;
2. Complete and submit, through Your Employer, an Enrollment Form, including Dependents, if any, during an enrollment period;
3. Provide any additional information We need to determine eligibility, if requested by Us; and
4. Agree to pay Your portion of the required premium, if required by the Employer.

DEPENDENT ENROLLMENT ELIGIBILITY
1. You may enroll Your current Dependent(s) at the same time You initially enroll.
2. You may enroll any new Dependent who first meets the definition of Dependent, after Your Enrollment Date, by completing and submitting an Enrollment Form to Us through Your Employer. Your Enrollment Form must be submitted to Us within 31 days after the date on which Your Dependent first meets the criteria for a Dependent.
   A. If Your new Dependent is a newborn child, coverage will be provided and premium charged for the initial period (Initial period is from the date of birth until 31 days after the date of birth). To continue coverage for Your newborn child, You must notify Us within 31 days and pay the required premium.
   B. If Your new Dependent is an adopted child or a child placed in Your home for adoption, coverage will be provided and premium charged from the date of adoption or the date of placement for adoption until 31 days after the date of adoption or date of the date of placement for adoption. To continue coverage of an adopted child or child placed for adoption, You must submit an Enrollment Form within 31 days after the date the child is placed for adoption or the date the adoption becomes final.

EMPLOYEE AND DEPENDENT ENROLLMENT PERIODS (NOT APPLICABLE TO LATE ENROLLEES)
There are two types of enrollment periods for obtaining coverage under the Policy:

1. The Initial Enrollment Period is the period of time during which an Employee or Dependent is first eligible to enroll under the Policy. If You or Your Dependent are enrolling during the Initial Enrollment Period, the Initial Enrollment Period will be as follows:
   A. With respect to an Employee or Dependent at the time of the Initial Enrollment Period, You must submit an Enrollment Form not later than the 31st day after the date employment begins or on completion of the Service Waiting Period.
   B. If Your Dependent is a newborn child who is born after the Initial Enrollment Period, You must notify Us within 31 days after the newborn child's birth. Coverage will be provided and premium charged for the initial period (Initial period is from the date of birth until 31 days after the date of birth) for the child. To continue coverage for Your newborn child beyond the 31 days, You must notify Us within 31 days and pay the required premium for your newborn child. In addition to Your newborn child, You may enroll Your eligible spouse at the time You enroll Your newborn child.
   C. If Your Dependent is an adopted child or child placed for adoption, and the adoption or placement for adoption begins after the Initial Enrollment Period, You must notify Us in writing within 31 days after the date of adoption or date of placement for adoption and any additional premium for the child that is necessary to continue coverage beyond the initial 31 day period must be paid. In addition to Your adopted child or child placed for adoption, You may enroll Your eligible spouse at the time You enroll Your adopted child or child placed for adoption.
   D. If You are an eligible Employee who waived coverage during the Initial Enrollment Period and get married after the Initial Enrollment Period, You may enroll both Yourself, Your newly eligible spouse and any of Your spouse's children by submitting an Enrollment Form within the first 31 days from the date of marriage.

2. A Special Enrollment Period is a period after the Initial Enrollment Period ends, if all of the following occur:
   A. You or Your Dependent were covered under a group Health Benefit Plan at the time of Your Initial Enrollment Period; and
   B. You or Your Dependent declined enrollment during the Initial Enrollment Period; and
   C. If required by Your Employer, You stated in writing that coverage under another group Health Benefit Plan was the reason that You or Your Dependent declined enrollment; and
   D. Your coverage or Your Dependent's coverage:
      1) Was under a COBRA Continuation Provision and the coverage under such provision was exhausted; or

      2) Was not under COBRA Continuation Provision and any of the following occurs:

         a. You or Your Dependent is no longer eligible for the other coverage as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment;
         b. The employer sponsoring such other coverage terminates the employer's contributions toward such coverage;
         c. Your Dependent no longer qualifies as a Dependent under the other coverage;
         d. The other coverage no longer offers any benefits to a class of similarly situated individuals to which You or Your Dependent belonged;
         e. The other coverage terminates a benefit package option; or
         f. You or Your Dependent have a claim denied due to the exhaustion of the lifetime limit on all benefits under the plan.

   E. If You or Your Dependent have a Special Enrollment Period as described above, the length of the Special Enrollment Period during which You and/or Your Dependent may submit an Enrollment Form will be as follows:
      1) 31 days beginning on the date of the termination of coverage or the date on which the employer contributions end; or
      2) 30 days from the date on which You or Your Eligible Dependent first receives notice that a claim has been denied under the other plan due to the exhaustion of the lifetime limit on all benefits.

LATE AND OPEN ENROLLEE ELIGIBILITY (EMPLOYEE OR DEPENDENT)
An Employee or Dependent who does not submit an Enrollment Form during the Initial Enrollment Period and who does not qualify for a Special Enrollment Period is a Late Enrollee.

1. Late Enrollees may only enroll during the Plan's Open Enrollment period. Open Enrollment means a 31-day period provided annually during which an Employee and his/her Dependents may enroll for coverage.
2. The Effective Date of coverage for a Late Enrollee that enrolls during the Open Enrollment period under the Policy will be the first day of the month next following the date We receive the Enrollment Form. Pre-Existing Conditions will not be covered until the Late Enrollee is continuously covered under the Policy for a period of 18 months following the Late Enrollee's Enrollment Date.

COURT ORDERED CUSTODY OF CHILDREN
Coverage is provided to a child in the court ordered custody of an Employee on the same basis as a newborn Dependent child.

We must receive notification within 31 days of the date on which the court order establishing custody of the child was issued and any additional premiums that are due for the coverage of the child must be paid. In order to establish court ordered custody, You must send Us a copy of the court order that establishes that You have full legal custody of such child.

ENROLLMENT
If Your or Your Dependent is entitled to enroll during an Initial Enrollment Period or Special Enrollment Period, You must submit an Enrollment Form for Yourself and/or Your Dependent on or before the applicable enrollment deadline as described in this Certificate. You may obtain an Enrollment Form from Your Employer. The Enrollment Form must be received by Us on or before the applicable enrollment deadline as described in this Certificate in order for You not to be considered a Late Enrollee

PART 3 – EFFECTIVE DATE OF INSURANCE

EMPLOYEE EFFECTIVE DATE

Your Effective Date of coverage under the Policy, excluding Late Enrollees, will be determined as follows:

1. If You enroll for coverage when the Employer enrolls for coverage, the coverage will be effective on the Employer's Effective Date.
2. If You become eligible after the Employer's Effective Date and enroll during a Service Waiting Period, an Initial Enrollment Period or a Special Enrollment Period, coverage will be effective [subject to receipt of the Enrollment Form by Us][the first day next following the end of any applicable Service Waiting Period][the first day of the Initial Enrollment Period] [the first day of the Special Enrollment Period]. [the first day or the fifteenth day of the month next following the later of the end of any applicable Service Waiting Period or [receipt of the Enrollment Form by Us].]

DEPENDENT EFFECTIVE DATE

The Effective Date of a Dependent's coverage under the Policy, excluding a Late Enrollee, a newborn child, an adopted child, or a child placed for adoption (See Dependent Enrollment Eligibility provisions above) depends on when You enroll the Dependent. The Dependent's Effective Dates are as follows:

1. If the Dependent is eligible for coverage when the Employer enrolls for coverage, the coverage for the Dependent will become effective on the Employer's Effective Date if You enroll the Dependent for coverage at that time;

2. If You first become eligible after the Employer's Effective Date and You enroll the Dependent during Your Initial Enrollment Period, the coverage for the Dependent will be effective on the same date that Your coverage becomes effective;

3. If the Dependent is a new spouse or step-child who first becomes eligible after Your Effective Date and You timely enroll the new spouse or step-child as described above, coverage will become effective as of [the date of marriage][or the first or fifteenth day of the month next following the date on which We receive the Enrollment Form];

4. If the Dependent is a newborn child who is born after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the date of birth;

5. If the Dependent is an adopted child or a child placed for adoption after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the date of the adoption or date of placement for adoption; or

6. If the Dependent qualifies as a Dependent for any other reason and first meets the definition of Dependent after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of [the date the Dependent qualifies as a Dependent][or the first or fifteenth day of the month next following the date on which We receive the Enrollment Form].

Services or supplies that are payable as Covered Charges under the Policy are covered from the Effective Date; *provided however*, services or supplies for a condition that is covered under an extension of benefits from previous health insurance coverage or other benefit arrangement will not be covered under the Policy until the extension of benefits under the prior health insurance coverage or benefit arrangement ends.

PART 4 – MEDICAL MANAGEMENT

HEALTH CARE COORDINATION

Health Care Coordination is the Policy program conducted by the Health Care Coordinator designated by Us which:

A. identifies cases involving the Insured Person in a clinical situation with the potential for catastrophic claims;
B. assesses those cases for the appropriate level of patient care and the setting in which it is received;
C. develops, introduces and implements viable Alternate Treatment Plans for those cases that maintain or enhance the quality of patient care; and
D. provides cost controls by implementing the agreed upon Alternate Treatment Plan.

The Alternate Treatment Plan is a specific written document developed by the Health Care Coordinator in charge of the case receiving Health Care Coordination. This document is developed through discussion and agreement with the Insured Person or legal guardian (if necessary), the attending Physician and Us. It includes:

A. Treatment Plan objectives;
B. course of treatment planned to accomplish those objectives;
C. responsibility of each party (Health Care Coordinator, attending Physician and Insured Person and his Family, if any) in implementing the plan; and
D. estimated cost and savings.

If We agree with the Health Care Coordinator, the attending Physician and Insured Person on an Alternate Treatment Plan, We may pay incurred Eligible Expenses at a higher Coinsurance Percentage for services and supplies specified in the Alternate Treatment Plan. In the event the approved Alternate Treatment Plan specifies services or supplies not considered as Eligible Expense under the terms and provisions of the Policy, payment of benefits under the Policy for such services or supplies shall require written approval by Us. If written approval is granted, payment of benefits under the Policy for those services or supplies shall be on the same basis as if those services or supplies were Eligible Expense.

NO INSURED PERSON IS REQUIRED TO ACCEPT AN ALTERNATE TREATMENT PLAN RECOMMENDED BY THE HEALTH CARE COORDINATOR**.**

PROVIDER NETWORKS

Reimbursement for Covered Charges varies depending on the Provider that the Insured Person selects to provide treatment, services or supplies. An In-Network Provider has affiliated with an organization, association or entity, such as a preferred Provider organization or managed care organization that has established a network of Providers in a specific Geographic Area to provide medical treatment, services and supplies at predetermined rates. An Out-of-Network Provider is a Provider who is not participating in Your Provider network. We make available selected Network(s) to provide an Insured Person an opportunity to select an In-Network Provider for treatment, services or supplies. Your Employer selects the Provider network on behalf of all Employees. If an Insured Person uses an In-Network Provider, We will pay benefits for that treatment, service or supply at the In-Network Provider benefit level as specified in the Schedule of Benefits. If treatment, services or supplies are obtained or received from an Out-Of-Network Provider, unless otherwise stated herein, the following applies: (i) Covered Charges will be reimbursed at the Out-Of-Network Benefit Level; (ii) Charges will be reduced to the Reasonable and Customary Charges for such treatment, service or supply before being considered a Covered Charge; and (iii) the Insured Person will be responsible for any portion of the charges that exceed the Reasonable and Customary Charges for such treatment, service or supply.

We shall not penalize an Insured Person or subject an Insured Person to the Out-of-Network level of benefits unless In-Network Providers are reasonably available to the Insured Person without unreasonable delay.

We will notify You not later than 30 days after Our receipt of termination from an In-Network Provider.

Upon termination of an In-Network Provider contract, We will pay for Covered Charges rendered by such Provider to an Insured Person under the care of such Provider at the time of termination until such services are completed, unless reasonable and medically appropriate arrangements for assumption of such services by another In-Network Provider are made.

When Covered Charges are incurred from an Out-of-Network Provider for Emergency Services, benefits will be paid at the In- Network benefit level shown in the Schedule of Benefits, until the Insured Person is stabilized and can be safely transported to an In-Network Provider as determined by the utilization review manager and the attending Physician. Otherwise, benefits will be reduced to the Out-of-Network Coinsurance Percentage shown in the Schedule of Benefits.

We do not arrange or provide treatment, services or supplies. It is always the Insured Person's responsibility to select a health care Provider of their choice. We have no control over, and are not responsible for, the actions or lack of actions of any Provider or Provider organization pertaining to any treatment, services or supplies rendered to an Insured Person.

[PRE-AUTHORIZATION PROGRAM
The Pre-Authorization Program is a prospective review that allows Us to determine whether the medical care or health care services proposed to be provided to the Insured Person are Medically Necessary and appropriate. The Pre-Authorization Program includes a list of certain medical care and health care services that require preauthorization as a condition of Our payment to a Provider under the Policy without a penalty. On receipt of a request from a Provider for Pre-Authorization, We will review and issue a determination indicating whether the proposed medical care or health care services are preauthorized. The determination will be issued and transmitted not later than the third calendar day after the date the request is received by Us. When We have pre-authorized medical care or health care services, We will not deny or reduce payment to the Physician or health care Provider for those services based on Medical Necessity or appropriateness of care unless the Physician or Provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services. The Pre-Authorization penalty amount is specified in the Schedule of Benefits applicable to Covered Charges incurred in connection with an Inpatient Confinement or other specified medical care or health care services when the Insured Person does not comply with Pre-Authorization. The Pre-Authorization penalty amount is in addition to the applicable Yearly Deductible Copay and Coinsurance and does not accumulate toward any Yearly maximum benefit amount. If the Insured Person complies with Pre-Authorization, the Pre-Authorization penalty amount will not apply. Pre-Authorization is required of all proposed Inpatient Confinements for more than 23 hours. Pre-Authorization is also required of proposed medical care and health care services, as specified in the Schedule of Benefits below.]

[PRE-AUTHORIZATION OF NON-EMERGENCY INPATIENT SERVICES
To request Pre-Authorization, the Insured Person or the Insured Person's attending Physician must contact the designated Pre-Authorization service at least 48 hours prior to obtaining the requested treatment, service or supply. The Pre-Authorization service may be reached by writing; or by telephone during normal business hours each business day. The name of the Pre-Authorization service and instructions are provided to each Insured Person. The Insured Person will be requested to provide:

1. name, address and the telephone number of the attending Physician;
2. the proposed treatment plan;
3. the Insured Person's authorization (or, if a minor, authorization on his behalf) to release medical information.

The Pre-Authorization service will then consult with the Insured Person's attending Physician. If the Pre-Authorization service concurs with the Insured Person's attending Physician with the appropriateness of the setting and Medical Necessity of the proposed treatment plan, the Pre-Authorization service will notify the Insured Person in writing and the Insured Person will be deemed to have complied with the Pre-Authorization requirement described herein.

The Pre-Authorization service may also conduct a continued stay review for any ongoing Inpatient Confinement. The continued stay review is a process of monitoring an Insured Person's progress on a daily basis to determine if the Insured Person will be discharged within the pre-authorized number of days and to determine the appropriate number of additional days of stay that may be required according to the Insured Person's condition and plan of treatment. Hospital admissions will be monitored to assure that the Insured Person will be discharged timely. The attending Physician and the Hospital utilization review nurses will be contacted to determine the progress of the Insured Person and the need, if any, for an extension of authorized Hospital days. If an extension of the Inpatient stay is not authorized for all or part of the requested day(s), the Insured Person and the attending Physician will be notified.

In absence of Pre-Authorization, benefits are subject to the penalty as specified in Your Schedule of Benefits.

No benefits will be paid for Covered Charges incurred for any Inpatient Hospital confinement or treatment plan which extends beyond the number of days deemed by the Pre-Authorization service to be Medically Necessary.

Pre-Authorization is not a guarantee of payment; however we will not deny or reduce payment to the Physician or Provider for those Covered Charges based on Medical Necessity or appropriateness of care. Payment of benefits will be determined by Us in accordance with and subject to all the terms, conditions, limitations and exclusions of the Policy.

If the Pre-Authorization service does not concur with the Insured Person's Physician, the Pre-Authorization service will so notify the Insured Person in writing and the Insured Person will not be deemed to be in compliance with the Pre-Authorization requirement described herein and the additional deductible or limitation on extended number of days will apply.]

[PRE-AUTHORIZATION OF EMERGENCY INPATIENT CARE
Inpatient Confinements for an Emergency Medical Condition must be authorized in the same manner as a non-emergency Inpatient Confinement; however, the Insured Person or the Insured Person's Physician may notify the Pre-Authorization service of the Emergency Inpatient confinement within 48 hours of the Inpatient Admission or as soon as reasonably possible and be in compliance with the Pre-Authorization requirement. The attending Physician must verify that an Emergency condition existed.

In the absence of Pre-Authorization for an Inpatient Confinement for an Emergency Medical Condition, benefits are subject to the additional Deductible specified in the Schedule of Benefits.

If an Insured Person is taken to an Out-Of-Network Provider Hospital for an Emergency Medical Condition, Inpatient Hospital Confinement benefits will be paid by Us at the In-Network level of benefit as specified in the Schedule of Benefits. However, the Insured Person must arrange transfer to an In-Network Hospital within 48 hours, or as soon as the transfer may take place without detriment to the Insured Person's health. Otherwise, benefits will be reduced to the Out-Of-Network Provider benefit level.]

[PRE-AUTHORIZATION OF PREGNANCY
You are not required to obtain Pre-Authorization for Pregnancy or for a post-delivery Inpatient confinement of 48 hours or less for a vaginal delivery or 96 hours or less for delivery by Cesarean Section.

If, following delivery, Your Physician determines that You need to remain confined in a Hospital for more than 48 hours following vaginal delivery or 96 hours following delivery by Cesarean Section, You or Your Physician must notify the Pre-Authorization service of the continuing Hospital Inpatient confinement as soon as reasonably possible following the determination to continue Your Hospital Inpatient Confinement.]

[PRE-AUTHORIZATION OF OTHER NON EMERGENCY MEDICAL CARE OR HEALTH CARE SERVICES
Pre-Authorization is required in order to receive benefits for the care, treatment and services listed below without a penalty. The Insured Person is responsible for assuring that the required Pre-Authorization is received before the charges are incurred by calling the designated Pre-Authorization service. Failure to comply with the Pre-Authorization requirement will result in assessment of the penalty shown in the Schedule of Benefits.
The Insured Person must obtain Pre-Authorization for the following other non-emergency medical care or health care services, as shown on the Schedule of Benefits.]

PART 5 – BENEFIT PROVISIONS

We will pay Covered Charges due to Injury or Sickness. Covered Charges may during a Year, be subject to Copays, the Deductible, Coinsurance Percentage and Coinsurance Limit, as shown in the Schedule of Benefits. Covered Charges must be incurred while this coverage is in force, and are subject to the terms, conditions, limitations, exclusions, and maximums stated in the Policy, this Certificate and the Schedule of Benefits.

In-Network. Covered Charges incurred from Preferred Providers will be paid according to the Copay, Deductible, Coinsurance Percentage, and Coinsurance Limit shown in the Schedule of Benefits for In-Network Services, and will be based on the Negotiated Rate.

Out-of-Network. Covered Charges incurred from an Out-of-Network Provider will be paid according to the Deductible, Coinsurance Percentage, and Coinsurance Limit shown in the Schedule of Benefits for Out-of-Network services, and will be based on Reasonable and Customary Charges.

BENEFITS MAY BE REDUCED OR EXCLUDED WHEN SERVICES ARE RECEIVED OUT-OF-NETWORK. THIS MAY ALSO INCLUDE AN ADDITIONAL DEDUCTIBLE, REDUCED COINSURANCE PERCENTAGE AND A HIGHER COPAY.

Using Your ID Card. Your ID card identifies You as an Insured Person in the PPO program. You are responsible for showing Your ID card to the Provider at the time of service. If You fail to show Your card before receiving any medical services, the Provider may not recognize You as a PPO Insured Person and Your benefits may be subject to the Out-of-Network Copay, Deductible, Coinsurance Percentage and Coinsurance Limit as if they were rendered by an Out-of-Network Provider.

Use Any Provider You Choose. You are not required to seek treatment from a PPO Provider. Each Insured Person is free to elect the services of any Provider and benefits payable will be in accordance with the terms and conditions of Your coverage under the Policy.

We do not represent Physicians or warrant the medical competence or ability of a PPO Provider, or their respective staff, nor do We have any liability or responsibility for any actions or inactions of a PPO Provider or their staff.

Maximum Benefit. The maximum amounts of benefits payable to, or on behalf of, each Insured Person for all Injuries and Sicknesses are shown in the Schedule of Benefits.

Deductibles. The Deductibles listed in the Schedule of Benefits will apply only once during a Year.

PART 6 – COVERED CHARGES

Covered Charges are the Negotiated Rate or those Reasonable and Customary Charges incurred for services and supplies listed below which are Medically Necessary. A Covered Charge is "incurred" on the date the service or treatment is provided or the supply is obtained. Covered Charges must be incurred while Your coverage is in force. The following benefits are paid for Covered Charges at the levels indicated in the Schedule of Benefits.

1. INPATIENT FACILITY SERVICES

Benefits are payable for the following Inpatient Hospital Services:

A. Room, board and general nursing service, when You occupy:

1) a Hospital room with 2 or more beds, known as a semi-private room or ward; or
2) a private room. The amount of benefits for a private room is limited to the Hospital's semi-private room rate, or if there is no semi-private room rate, 90% of the private room rate; or
3) a bed in a special care unit. A special care unit is a unit whose main purpose is to provide an intensive level of care for critically ill patients. Examples of a special care unit are a coronary care unit or an Intensive Care Unit.

B. Miscellaneous Services and Supplies. Examples include:

1) use of operating, and treatment rooms, and equipment;
2) drugs (excluding take home drugs);
3) administration of blood and blood processing (including the cost of blood, plasma or fractionalized blood products);
4) anesthesia, anesthesia supplies and services;
5) medical and surgical dressings, supplies, casts, and splints;
6) diagnostic services;
7) therapy services;
8) nursing services in a special care unit, other than the portion payable under Section 1 above; and
9) one visit per Physician per day during a covered Hospital confinement due to an Injury or Sickness.

2. SURGICAL SERVICES

Benefits are payable as specified in the Schedule of Benefits if You require surgery due to an Injury or Sickness. The surgery must be performed in a Hospital, Hospital Outpatient department or Ambulatory Surgical Center or Physician office. The following services are eligible for coverage:

A. Surgical Services. Services must be performed by a Physician. Additional payment will not be made for related pre- and post- operative care billed separately by the Physician which would or should be customarily included as part of the fee for the surgery. Benefits for surgical services will be paid as

follows:

1) **Single Surgical Services.** When a single surgical service is provided by 2 or more Physicians, the benefit will be the same as if the surgical care was rendered by one Physician.
2) **Multiple Surgical Services.** The benefit payable if 2 or more surgical services are performed at the same time through different openings or approaches, is the sum of the following amounts: the greatest Covered Charge for one of the surgical procedures, plus one-half of the Covered Charge for each of the other surgical services performed.
3) **Physician Office Surgery (Major)**
This benefit is payable for the In-Network or Out-of-Network Physician's actual charge for surgical and endoscopic services as specified in the Schedule of Benefits.
4) **Physician Office Surgery (Minor)**
This benefit is payable for the In-Network or Out-of-Network Physician's actual charge for surgical and endoscopic services as specified in the Schedule of Benefits.

B. **Surgical Assistant.** Services of a Physician who actively assists the operating surgeon in the performance of surgery are covered. The benefit payable will not exceed [20%] of the benefit amount payable for the primary surgeon's fee. No coverage will be provided for a Physician on call or placed on standby.

C. **Anesthesia.** Benefits are payable for the administration of anesthesia ordered by the attending Physician and rendered by a Physician in connection with a covered service. If a Certified Registered Nurse Anesthetist (CRNA) is utilized, total benefits for the Anesthesiologists and the CRNA will be limited to the Reasonable and Customary amount of the Anesthesiologist for the anesthesia service. If the only charge submitted for payment is for the services of a CRNA, then benefits will be limited to the Reasonable and Customary Charge of a CRNA for the anesthesia service.

D. **Miscellaneous Services.** Benefits are payable for Covered Charges for the following services provided and supplies obtained in the course of receiving surgical services.

1) the processing and administration of blood and blood components, and for whole blood, blood plasma and blood products that are not replaced by a donor for an Insured Person;
2) heart pacemaker;
3) medical and surgical dressings, casts, splints, braces, and crutches;
4) oxygen and other gases, as well as charges for their administration;
5) nursing services in an Ambulatory Surgical Center; or
6) the use of operating and treatment rooms, and equipment, in an Ambulatory Surgical Center.

3. PHYSICIAN OFFICE VISITS

Benefits are payable for Physician Office Visits.

In-Network Physician Office charges for examination, evaluation or consultation will be subject only to the Physician Office Visit Copay amount, limited to one office visit per day. However, charges for other treatment received during a Physician Office Visit are subject to the In-Network Deductible, Coinsurance Percentage and Coinsurance Limit.

Out-of-Network charges will be subject to the Out-of-Network Deductible, Coinsurance Percentage, and Coinsurance Limit shown in the Schedule of Benefits.

4. HUMAN ORGAN, TISSUE, AND BONE MARROW TRANSPLANTS

Benefits are payable for human organ transplant or tissue transplant or replacement. However, the only human organ transplants considered to be Covered Charges are those that are not considered Experimental.

An Insured Person may be directed to a facility designated by Us as a Transplant Network for certain services. If the Insured Person agrees to use the Transplant Network to which We direct the Insured Person, We will provide benefits for the Insured Person's transportation to and from the Transplant Network for the initial treatment, evaluation and for the resulting confinement.

If the Insured Person receives a covered human organ or tissue transplant, the donor's expenses will be considered to be the Insured Person's expenses even if the donor is also insured under the Policy as an Employee or Dependent. We will pay benefits for the donor's Covered Charges to the extent an actual charge is made that is not paid or payable by any other plan covering the donor.

5. DIAGNOSTIC TESTING SERVICES [–] [Minor]
Benefits are payable for diagnostic tests including related professional fees, incurred on a non-Inpatient basis. Diagnostic tests include,: x-rays, laboratory tests, electrocardiograms (EKGs) and electroencephalograms (EEGs).

6. SPECIALTY DIAGNOSTIC SERVICES[–] [Major]
Benefits are payable for specialty diagnostic tests, and including related professional fees, incurred on an Outpatient basis. Specialty Diagnostic Tests include nuclear medicine imaging, radioimmune assay, ultrasound/echography, computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), angiography, arthroscopy, cholangiography, cholecystography, cytourethroscopy, endoscopy, duodenoscopy, hysterosalpingography, laparoscopy, myelography, pyelography, pancreatography, vasography, or venography.

7. REHABILITATION SERVICES
Benefits are payable for Rehabilitative Services as shown in the Schedule of Benefits including intensive physical, or speech therapy to treat acute conditions or Injuries, which are provided in a rehabilitative unit of a Hospital or a Rehabilitative Facility, when ordered by the treating Physician and provided by a licensed or registered therapist or physiatrist. To be eligible for coverage, services must begin within 7 days of a discharge from a covered acute care Inpatient Hospitalization and must be related to the Injury or Sickness resulting in the Hospitalization. We will evaluate the Medical Necessity of such services by monitoring progress toward expected outcome(s). Coverage for Rehabilitation Services will cease when progress toward the established rehabilitation outcome(s) has plateaued or the outcome(s) can be achieved utilizing a less intensive setting. The maximum number of days covered for Inpatient Rehabilitation Services per Injury or Sickness will not exceed the amount shown in the Schedule of Benefits.

8. THERAPY SERVICES
Benefits are payable for the services of a physical therapist, Occupational Therapist, inhalation therapist (respiratory) and speech therapist. Outpatient short-term rehabilitation, Occupational Therapy, and physical therapy services are covered when the provision of such services can be expected to result in the significant improvement of an Insured Person's condition, or the maximum benefit as shown in the Schedule of Benefits has been reached.

9. OUTPATIENT MEDICAL THERAPY
Benefits are payable for facility charges and professional fees incurred for radiation therapy, including treatment planning, chemotherapy, and hemodialysis therapy for treatment following a covered Hospital confinement or a covered Outpatient surgery.

10. ALLERGY SERVICES
Benefits are payable for allergy testing and allergy injections.

11. HEARING AND SCREENING SERVICES
Benefits are payable for routine hearing and routine vision examination by a Physician as shown in the Schedule of Benefits.

12. PROSTHETIC DEVICES
Benefits are payable for prosthetic devices in an amount equal to the amount provided under Federal laws for health insurance for the aged and disabled, 42 USC 1395k et seq. and 42 CFR 414.202 et. seq. Covered Charges are limited to the most appropriate model that adequately meets the medical needs of the Insured Person as determined by the Insured Person's treating Physician. Repairs and replacements of prosthetic devices are also covered unless necessitated by misuse or loss.

For the purposes of this benefit, the following definition applies:

Prosthetic devices means an artificial device to replace in whole or in part, an arm or a leg.

13. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY
Benefits are payable for breast reconstructive surgery incident to a mastectomy. Breast reconstruction shall include:

A. reconstruction of the breast upon which the mastectomy has been prescribed;
B. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. prostheses and treatment for physical complications, including lymphedemas, at all stages of mastectomy;

14. DIABETES EQUIPMENT AND SUPPLIES

Benefits are payable for Diabetes equipment and supplies for which a Physician has written an order including but not limited to:

A. blood glucose monitors, including non-invasive monitors and monitors designed to be used by or adapted for the legally blind;
B. test strips specified for use with a corresponding glucose monitor;
C. lancets and lancet devices;
D. visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
E. insulin and insulin analog preparations;
F. injection aids, including devices used to assist with insulin injection and needleless systems;
G. insulin syringes including pen delivery systems for the administration of insulin;
H. biohazard disposal containers;
I. insulin pumps, both external and implantable, and associated appurtenances, which include:
    1) insulin infusion devices;
    2) batteries;
    3) skin preparation items;
    4) adhesive supplies;
    5) infusion sets;
    6) insulin cartridges;
    7) durable and disposable devices to assist in the injection of insulin; and
    8) other required disposable supplies;
J. repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
K. Prescription Medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level;
L. podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
M. glucagon emergency kits.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies will be covered if determined to be Medically Necessary and appropriate by a treating Physician through a written order.

All supplies, including medications, and equipment for the control of diabetes must be dispensed as written, including brand name products, unless substitution is approved by the Physician who issues the written order for the supplies or equipment.

15. DIABETES SELF-MANAGEMENT TRAINING

Benefits are payable for diabetes self-management training including medical nutrition education limited to:

A. Three (3) Medically Necessary visits upon initial diagnosis or if the diagnosis was made within 1 year prior to the Effective Date of this coverage, up to 3 Medically Necessary visits within 1 year after that Effective Date; or
B. up to 2 Medically Necessary visits upon a determination of a significant change in the Insured Person's symptoms or medical condition.

16. PREGNANCY/MATERNITY

Benefits are payable if indicated on the Schedule of Benefits for maternity services provided to an Eligible Employee, Dependent spouse and child.

Coverage includes treatment, services or supplies furnished in connection with a routine Pregnancy and delivery by elective cesarean section for:

A. A minimum of forty-eight (48) hours after an uncomplicated vaginal delivery; or
B. A minimum of ninety-six (96) hours after delivery by uncomplicated cesarean section.

The length of stay may be shortened at the discretion of the attending Physician after conferring with the mother.

This benefit includes routine well newborn nursery care while the newborn is Hospital-confined immediately after birth and includes room, board and other normal care for which a Hospital makes a charge.

This benefit also includes participation in the Expanded Alpha Feto Protein (AFP) program, which is a statewide prenatal testing program administered by the state Department of Health Services.

[Benefits for a newborn while in the Hospital are payable only under the mother's coverage.]

[The newborn establishes a claim as an individual Dependent.]

17. COMPLICATIONS OF PREGNANCY

Benefits are payable for Complications of Pregnancy in the same manner and to the same extent as for any other Sickness covered under the Policy.

18. MENTAL HEALTH CONDITIONS

Benefits are payable if indicated on the Schedule of Benefits for care and treatment of Mental Health Conditions in each Year to each Insured Person as specified in the Schedule of Benefits.

19. SUBSTANCE USE DISORDERS

Benefits are payable if indicated on the Schedule of Benefits for care and treatment of Substance Use Disorders in each Year to each Insured Person as specified in the Schedule of Benefits.

20. DENTAL ANESTHESIA

Benefits are payable for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Center setting, when the clinical status or underlying medical condition requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital or Ambulatory Surgical Center, for children below the age of 7 years, persons who are developmentally disabled regardless of age, and persons whose health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Charges for the dental procedure itself (including the professional fee of the dentist) are not covered.

21. AMBULANCE SERVICES

Benefits are payable, as shown in the Schedule of Benefits, for a local, professional ambulance service to and from the nearest available Hospital or other medical facility which is appropriately staffed and equipped to treat the Insured Person's Injury or Sickness. We will not pay toward charges incurred for non-Emergency ambulance service by air unless such service is needed because of an Emergency Medical Condition. Transportation undertaken to secure treatment by a personal Physician or by a Physician or institution of greater renown or greater specialization is not covered. Preauthorization is required for non-emergency licensed ambulance services to transport an insured form a Hospital or other health care facility to another Hospital or health care facility. Services must be Medically Necessary and appropriate.

22. EMERGENCY SERVICES

Benefits are payable for Emergency Services directly provided by a health care Provider to treat an Insured Person's Emergency Medical Condition. Emergency Services do not require Pre-Authorization. Emergency Services for a covered Sickness or Injury received by an Out-of-Network Provider will be paid at the In-Network Provider benefit level subject to the same cost sharing requirements, such as Deductible, Copay and Coinsurance requirements that would otherwise apply as if the Emergency Services were provided by an In-Network Provider.

The Emergency Services Copay applies as shown in the Schedule of Benefits.

23. SKILLED NURSING FACILITY SERVICES

Benefits are payable for room, board, and general nursing care while confined in a Skilled Nursing Facility if:

A. the Skilled Nursing Facility stay begins within 14 days after a Hospital stay;
B. the stay is for the same Injury or Sickness as the Hospital stay; and
C. a Physician certifies that skilled nursing care is needed for the treatment of the Insured Person's condition.

Covered Skilled Nursing Facility charges will be limited to:

A. the most common daily semi-private room rate of the Hospital where the Insured Person was last confined; and
B. the number of days per Year and the Coinsurance Percentage shown in the Schedule of Benefits.

Successive stays in a Skilled Nursing Facility will be considered to be part of one period of Skilled Nursing Facility confinement if:

A. they result from the same or related causes; and
B. they are separated by a period of less than 6 months during which the Insured Person is not confined in either a Hospital or Skilled Nursing Facility.

24. HOME HEALTH CARE SERVICES

Benefits are payable for the continued care and treatment of an Insured Person who is under the direct care and supervision of a Physician but only if:

1. continued Hospitalization would have been required if home health care were not provided;
2. the home health treatment plan is established and approved by a Physician within 14 days after an Inpatient Hospital confinement has ended and such treatment plan is for the same or related condition for which the insured person was hospitalized; and
3. home health care commences within 14 days after the Hospital confinement has ended.

Home health care consists of, but are not limited to the following:

1. part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse;
2. part-time intermittent home health aid services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist;
3. physical occupation or speech therapy; and
4. medical supplies, drugs and medicines prescribed by a Physician and related pharmaceutical services, and laboratory services to the extent such charges or costs which have been covered under the Policy if the Insured Person had remained in the Hospital.

The number of home visits for which benefits are payable is limited to the number of such visits shown in the Schedule of Benefits in any year or in any continuous 12-month period for each person covered under the Policy. Except for a home health aide, each visit by a representative of a home health agency shall be considered as one home health visit. A visit of four hours or less by a home health aide will be considered as one home health visit.

Home health care benefits are specified in the schedule of benefits.

25. HOSPICE CARE AND RESPITE CARE SERVICES

Benefits are payable for care of an Insured Person with a life expectancy of six (6) months or less in a Hospice Care Program by a Hospice Team as specified in the Schedule of Benefits. The benefit period commences on the date the Insured Person is admitted on the referral of a Physician to the Hospice Care Program and ends six (6) months from that date, or on the date the Insured Person dies, whichever occurs first.

Covered Charges for Hospice Care and Respite Care are the Reasonable and Customary Charges made by a Hospice Care Program, including:

A. home care services;
B. Inpatient and Outpatient medical and non-medical care;
C. emotional support services to the Insured Person; and
D. bereavement counseling to immediate insured family members (spouse, parents and children) of the Insured Person within the three (3) month period following the death of the Insured Person, not to exceed a maximum of three (3) counseling visits.

Benefits for Hospice Care are in lieu of any similar benefits provided under any other Covered Charges provision of this Part.

26. PREVENTIVE CARE SERVICES

Benefits are payable for the following preventive care services without regard to any cost-sharing requirements such as Deductible, Copay or Coinsurance requirements that would otherwise apply. [Preventive Care Services must be received from an In-Network Provider or benefits will be denied.]:

A. Evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;
B. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved;
C. With respect to Insured Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

D. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph (A.) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

27. PRESCRIPTION DRUGS AND MEDICINES

Benefits are payable for prescription drugs and medicines on Our Formulary including Injectable and Specialty Medications which are in excess of the Copay per prescription order and Yearly Deductible Amount specified in the Schedule of Benefits. Prescription drugs and medicines not on Our Formulary are not covered.

Our Formulary is a list of Generic and Brand Name Drugs including Injectable and Specialty medications, that has been developed by a pharmacy and Therapeutics committee comprised of Physicians, pharmacists and other health care professionals.

This Benefit is not considered as Covered Charges under any other Benefit of the Policy. Payment of any benefits under this Benefit does not waive, or in any manner whatsoever affect, any Limitations and Exclusions of the Policy, including the Pre-Existing Condition Limitation.

Outpatient Covered Prescription Drug Charges

Outpatient covered Prescription Drug charges are those incurred by an Insured Person for Federal Drug Administration (FDA) approved drugs on our Formulary which are: lawfully obtainable only upon the written prescription of a Physician, not excluded below, and obtained from a licensed pharmacist.

Coverage is provided for contraceptive drugs and or devices approved by the United States Food and Drug Administration if this option is shown on the Schedule of Benefits.

Injectable and Specialty Medications

Injectable and Specialty Medications are covered if this option is shown on the Schedule of Benefits. To obtain Injectable and Specialty Medications, the Insured Person must contact a pharmacy Provider designated by Us as a specialty pharmacy Provider. If the Insured Person obtains the benefit from a Provider other than the specialty pharmacy Provider designated by Us, the Insured Person must pay for the services and will be reimbursed at the Negotiated Rate then in force for the specialty Provider. Benefits are subject to the Deductible, Coinsurance Percentage, Coinsurance Limit, and yearly maximum benefit.

Outpatient Prescription Drugs are separated into three categories:

A. **Generic Drugs.** These are Prescription Drugs that are chemically and therapeutically equivalent to brand name Prescription Drugs in the same class but are not protected by a patent. The FDA approves generic Prescription Drug as bioequivalent - meaning they perform in Your body the same as a brand preferred and/or brand non-preferred Prescription Drug. These Prescription Drug's are generally less costly than their brand-name counterparts.

B. **Brand Preferred Drugs.** Brand-name Prescription Drugs that have been determined to be superior or equal to brand non-Preferred Prescription Drugs, but are more cost effective.

C. **Brand Non-Preferred Drugs.** These brand-name Prescription Drugs have a more cost-effective therapeutic alternative.

Refer to Your Schedule of Benefits for the benefit level of each category.

If Your Physician writes a prescription that indicates a generic Prescription Drug may be substituted for a brand-name Prescription Drug and the Insured Person elects to obtain the brand name Prescription Drug instead of the generic Prescription Drug equivalent, the Insured Person will be responsible for the Insured Person's brand-name Copay plus the difference between the cost of the generic Prescription Drug and the brand-name Prescription Drug.

The list of Brand Preferred drugs is subject to change without notice. In addition, some drugs listed on the Brand Preferred list may not be covered Prescription Drugs in the Policy. Please refer to the list below for excluded Prescription Drugs.

Pharmacy Benefit Manager

A Pharmacy Benefit Manager (PBM) administers Your Outpatient Prescription Drug Benefit. The PBM has contracted with a network of In-Network pharmacies to dispense Outpatient Prescription Drugs at contracted rates.

A. If the dispensing Pharmacy is a member of the PBM, the Insured Person must show his or her Prescription Drug card to the Pharmacist (or where applicable, to the Physician) and pay the amount specified in the Schedule of Benefits based on the type of Outpatient Prescription Drug and the level of coverage available as specified in the Schedule of Benefits. The Pharmacy will then bill the PBM for the balance of the charges.

B. If the dispensing Pharmacy is not a member of the PBM, or if the Insured Person elects not to use his or her Prescription Drug card, the Insured must complete a direct reimbursement claim form, which is available from the PBM upon request, and submit it to the PBM, which will then reimburse the Insured Person as though the prescription card had been utilized.

In-Network Pharmacies provide the PBM with negotiated discounted rates. If the dispensing pharmacy is not a member of the PBM, or if the Insured Person does not use his or her Prescription Drug card, the Insured Person will be reimbursed on the same basis as would have been paid by the PBM to an In-Network Pharmacy.

An Insured Person is responsible for the payment of the following if the Prescription Drug was dispensed by an Out-of-Network pharmacy or where the Prescription Drug is dispensed at an In-Network Pharmacy, but the Insured Person elects a brand-name Prescription Drug when an equivalent generic Prescription Drug is available:

A. Any Copay, Deductible and Coinsurance as specified in the Schedule of Benefits;
B. The additional amount over what We would have paid a participating dispensing pharmacy;
C. The additional cost of any Prescription Drug which, at the request of the Insured Person or attending Physician, is not dispensed in accordance with the Maximum Allowable Cost list;
D. Prescription Drugs which are dispensed in excess of the dispensing limitation.

Dispensing Limitation

In order for expenses for Outpatient Prescription Drug to be considered Covered Charges , the dispensing Pharmacy may not dispense more than the following at one time:

A. For other than prescription mail orders - a -, ; See Your Schedule of Benefits regarding supply amounts or
B. For prescription mail orders - . See Your Schedule of Benefits regarding supply amounts

Right Of Recovery

We have the right to recover by direct payment from an Insured Person any expenses for Outpatient Prescription Drug paid by Us to the extent of the number of days, or doses, dispensed to the Insured Person beyond the date of insurance termination by reason of non-payment of premium.

Excluded Drugs

A. Over-the-Counter Drugs and Products, except diabetes drugs;
B. Fertility Agents or drugs for sexual dysfunction;
C. Vitamins (other than pre-natal);
D. Anti-Smoking aids, e.g. Nicorette, Nicaderm, Habitrol;
E. Hair loss medications, e.g. Rogaine, Monoxidil;
F. Immunization agents, biological sera, blood or blood plasma;
G. Investigational use or Experimental drugs;
H. Any charge for administration of injectable insulin;
I. Drugs covered under Workers' Compensation;
J. Anorectica drugs for weight control;
K. Medication taken, prescribed or administered while an Inpatient at a Hospital, Rest Home, Sanitarium, Extended Care Facility, Convalescent Hospital, Nursing Home or similar institution which operates a facility for dispensing pharmaceuticals;
L. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use;
M. Homeopathic medications;
N. Any drugs purchased outside the United States of America;
O. Abortifacients or other drugs or devices that terminate a pregnancy; or
P. Any drugs or medicines not on Our Formulary.

28. ACUPUNCTURE AND ACUPRESSURE

Benefits are payable if indicated on the Schedule of Benefits for acupuncture and acupressure as specified in the Schedule of Benefits.

29. MANIPULATIVE SERVICES

Benefits are payable if indicated on the Schedule of Benefits up to the maximum amount shown in the Schedule of Benefits per Insured Person for spinal manipulation, manual or electrical muscle stimulation, other manipulative or ultrasound therapy when performed by a Physician, and any other non-surgical treatment of the spine.

30. DURABLE MEDICAL EQUIPMENT

Benefits are payable if indicated on the Schedule of Benefits up to the Maximum shown Schedule of Benefits for the rental or purchase of Durable Medical Equipment (DME) that improves the function of a malformed body member or prevents further deterioration of an Insured Person's medical condition. Total rental payments, if any, will be limited to the purchase price of the equipment. A Physician must prescribe the Durable Medical Equipment for an Insured Person and submit a written statement of Medical Necessity. We will pay for the replacement of Durable Medical Equipment due to normal wear and tear.

If the DME device is covered, the supplies associated with the equipment will also be covered. Maintenance is not covered for purchase or rental equipment.

Durable Medical Equipment does not include supplies for short-term use or minor ailments, equipment which may be used by all family members, or items that may increase the value of Your property. Benefits are not provided for environmental control equipment, modifications to home property such as ramps, elevators and air conditioners, seatlift chairs, automotive vehicles, or modifications to automotive vehicles.

31. TEMPOROMANDIBULAR JOINT DISORDER

Benefits are payable if indicated on the Schedule of Benefits up to the maximum amount shown in the Schedule of Benefits for the care and treatment of temporomandibular joint disorder (TMJ).

32. INFERTILITY

Benefits are payable if shown as a Covered Charge on the Schedule of Benefits for Infertility services including consultations, examinations, diagnostic surgical services related to Hospitalizations or facilities, treatment and drug therapy for involuntary infertility. The level of benefits for all services, including the diagnostic work-up and testing to establish a cause of Infertility are specified in the Schedule of Benefits when obtained with prior authorization.

A. Covered Charges include artificial insemination (except for donor semen or eggs, and services and supplies related to their procurement and storage), subject to a maximum of one treatment period of up to three (3) cycles per Lifetime; AND **ONE** Gamete intrafallopian transfer (GIFT) **OR** IVF per lifetime. (Lifetime is defined to include services provided under this Policy or any other health insurance.) Medications for the treatment of Infertility require copay equal to 50% of the contracted prescription cost. Genetic testing and counseling are Covered Charges when medically indicated and are not subject to the Infertility Copayments.
B. No benefits shall be payable under the Policy for any expenses caused by, incurred for, or resulting from:
    1. Services and supplies to reverse voluntary, surgically induced infertility.
    2. Embryo transfers and any services and supplies related to donor sperm or sperm preservation for artificial insemination, are excluded, including all services involved in surrogacy.
    3. Frozen embryo transfers and Zygote Intra-Fallopian Transfer (ZIFT).
    4. ICSI, Intracytoplasmic Sperm Injection.
    5. Ova Sticks (a self-test for infertility).
    6. Ovum Transfer/Transplants or Uterine Lavage as part of infertility diagnosis or treatment.
    7. Sperm Donor, including the actual collection of the sperm.
    8. Sperm Storage. Storage is not for the treatment of a disease or medical condition and is not Medically Necessary.
    9. Infertility as a result of previous/prevailing elective vasectomy or tubal ligation, including, but not limited to, procedure reversal attempts and infertility treatment after reversal attempts.
    10. Artificial insemination/donor sperm in lieu of a partner is not covered.
    11. Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome).
    12. Experimental diagnostic studies, procedures or drugs used to treat or determine the cause of Infertility.
    13. Laboratory medical procedures involving the freezing or storing of sperm, ovum and/or pre-embryos.
    14. Inoculation of women with partner's white cells (considered Experimental).

For purposes of this benefit, the following definition applies:
Infertility means being pre-menopausal with the presence of a condition recognized by a Physician as a cause, or the inability to conceive a Pregnancy or to carry a Pregnancy to a live birth after one year or more of regular sexual relations without contraception.

33. AUTISM SPECTRUM DISORDER

Benefits are payable if indicated on the Schedule of Benefits for a Dependent child older than two years of age and younger than six years of age who is diagnosed with Autism Spectrum Disorder as specified in the Schedule of Benefits.

Coverage includes all Generally Recognized Services prescribed in relation to Autism Spectrum Disorder by the Dependent child's Physician in the treatment plan recommended by that Physician.

For purposes of this Benefit, the following definition applies:

"Generally Recognized Services" means services such as:

A. evaluation and assessment services;
B. applied behavior analysis;
C. behavior training and behavior management;
D. speech therapy;
E. occupational therapy;
F. physical therapy; or
G medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

33. PHENYLKETONURIA (PKU) TESTING AND TREATMENT

Benefits are payable for special dietary formulas and special food products for the therapeutic treatment of an Insured Person for phenylketonuria provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria.

34. COMPREHENSIVE PREVENTIVE CARE OF CHILDREN

Benefits are payable for comprehensive preventive care of Covered Dependent children 18 years of age and younger for: (a) periodic health evaluations; (b) immunizations; and (c) laboratory services in connection with periodic health evaluations.

35. CANCER SCREENING TESTS

Benefits are payable for all generally medically accepted cancer screening tests specified in the Schedule of Benefits including:

A. Annual cervical pap smear;
B. Mammography
   1) one baseline mammogram examination for each female Insured Person who is at least 35, but less than 40 years of age;
   2) one mammogram examination every 2 years or more frequently if ordered by a Physician for a female Insured Person who is at least 40 but less than 50 years of age;
   3) one mammogram examination every year for a female Insured Person age 50 and over; and
C. Prostate Cancer Screening

   Benefits are payable for a medically recognized diagnostic examination for the detection of prostate cancer.

   Coverage includes:
   1) a physical examination for the detection of prostate cancer; and
   2) a prostate-specific antigen test used for the detection of prostate cancer for each male who:
      a. is at least 50 years of age and is asymptomatic; or
      b. is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.
D. Colorectal Cancer Screening

   Benefits are payable for medically recognized diagnostic examinations and laboratory tests for colorectal cancer for Insured Persons who are 50 years of age or older, or less than fifty (50) years of age and at high risk for colorectal cancer according to the most current American Cancer Society colorectal cancer screening guidelines.for the detection of colorectal cancer.

36. ANTIBIOTIC THERAPY

Benefits are payable for antibiotic therapy administered intravenously in a home-health setting.

37. PROSTHETIC DEVICES - LARYNGECTOMY

Benefits are payable for prosthetic devices to restore a method of speaking for the Insured Person incident to a laryngectomy.

For the purposes of this benefit, the following definitions apply:

Laryngectomy means the removal of all or part of the larynx for Medically Necessary reasons, as determined by a licensed Physician and surgeon.

Prosthetic Device means and includes the provision of initial and subsequent Prosthetic Devices, including installation accessories, pursuant to an order of the Insured Person's Physician. This does not include electronic voice producing machines.

38. OSTEOPOROSIS
Benefits are payable for services related to diagnosis, treatment, and appropriate management of osteoporosis, including bone mass measurement technologies as deemed medically appropriate.

39. CANCER CLINICAL TRIALS
Benefits are payable for routine patient care costs incurred as a result of an Insured Person's participation in a phase I, phase II, phase III or phase IV Clinical Trial if the Insured Person's treating Physician recommends participation in the Clinical Trial after determining that participation in the Clinical Trial has a meaningful potential to benefit the Insured Person. For the purposes of this sub-paragraph, a Clinical Trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent. The Clinical Trial must either involve a drug that (1) is exempt under Federal regulations from a new application or that (2) is approved by one of the following: (A) One of the National Institutes of Health. (B) The Federal Food and Drug Administration in the form of an investigational new drug application. (C) The United States Department of Defense or (D) The United States Veterans Administration. We will not provide benefits that supplant a portion of a cancer Clinical Trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.

For purposes of this benefit, the following definition applies:

Clinical trial means a course of treatment provided to a patient for the purpose of prevention of reoccurrence, early detection or treatment of cancer.

40. AIDS VACCINE
Benefits are payable for a vaccine for AIDS that is approved by the federal FDA and that is recommended by the United States Public Health Service.

41. HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING
Benefits are payable for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

42. TELEMEDICINE
Benefits are payable for telemedicine.

For purposes of this benefit, the following definition applies:
Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a Physician and a Insured Person constitutes Telemedicine. For the purposes of this Definition, interactive means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

43. RECONSTRUCTIVE SURGERY
Benefits are payable for reconstructive surgery.

For purposes of this benefit, the following definitions apply:

Reconstructive surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection or disease to do either of the following:
a. To improve function.
b. To create a normal appearance, to the extent possible.
The definition also includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

Cleft palate means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

44. SPECIAL FOOTWEAR
Benefits are payable for special footwear as needed by Insured Persons who suffer from foot disfigurement, including disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or development disability.

45. PRENATAL DIAGNOSIS OF GENETIC DISORDERS OF THE FETUS
Benefits are payable for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in the event of a high risk Pregnancy.

46. LEAD SCREENING
Benefits are payable for the screening of Dependent children who are Insured Persons to determine the lead level contained in the blood.

47. TREATMENT FOR NICOTINE USE,
Benefits are payable for the treatment of an Insured Person for nicotine use as specified in the Schedule of Benefits.

48. SURGICAL SERVICES DIRECTLY AFFECTING THE UPPER OR LOWER JAWBONE
Benefits are payable for surgical services directly affecting the upper or lower jawbone, or associated bone joints of an Insured Person. This benefit does not include the provision of dental services.

49. ORTHOTICS
Benefits are payable for orthotic devices and services, including original and replacement devices, when prescribed by a Physician or ordered by a licensed health care provider acting within the scope of his or her license.

PART 7 – EXCLUSIONS AND LIMITATIONS

No benefits are payable for services, procedures, supplies, drugs, devices or treatment that are not Covered Charges or specifically provided in the Benefits sections of this Certificate.

In addition, no benefits are payable for, or relating to, the following services, procedures, supplies, drugs, devices or treatments, regardless of Medical Necessity:

1. **[Absence of Insurance** – expenses for a loss for which no charge would be made in the absence of health care coverage or for a service which your Physician advertises as a free service.
2. **Acupressure/Acupuncture** – beyond the benefit limits stated in Part 6 – Covered Charges and on the Schedule of Benefits.
3. **Addiction** – expenses related to nicotine addiction beyond the benefit limits stated in Part 6 – Covered Charges, caffeine addiction and non-chemical addictions including, but not limited to, gambling, sexual, spending, shopping, working and religious. This exclusion does not apply to Substance Use Disorders.
4. **Blood Storage** – expenses related to the storage of blood, except for autologous collection in preparation for surgery.
5. **Commission of a Felony** – expenses related to treatment of an Injury or Sickness of an Insured Person that occurs during or results from the commission of a felony or being engaged in an illegal occupation by the Insured Person.
6. **Cosmetic** – expenses related to Cosmetic Surgery or treatment to improve Your appearance or correct a deformity without restoring a physical bodily function, and complications resulting from Cosmetic Surgery or procedures. This exclusion does not apply to treatment of congenital anomalies of Eligible Dependents covered from birth or to craniofacial abnormalities of an Insured Dependent under 18 years of age. This also does not apply to treatment to correct conditions resulting from a covered Injury or Sickness occurring while Your coverage was in force under the Policy.
7. **Cryopreservation of bodily fluids**.
8. **Custodial Care** – expenses related to care provided in rest homes, health resorts, homes for the aged, halfway houses, or places mainly for domiciliary or Custodial Care.
9. **Dental Care** – expenses related to dental care. This exclusion does not apply to expenses resulting from a covered Injury to Sound Natural Teeth rendered within 1 year of the Injury
10. **Durable Medical Equipment** – beyond coverage provided in Part 6 – Covered Charges and on the Schedule of Benefits.
11. **Eating Disorders** – expenses related to treatment of eating disorders including, but not limited to, anorexia nervosa or bulimia beyond coverage for Mental or Nervous Disorders already provided in Part 6 – Covered Charges.
12. **Employment for Wage or Profit or Worker's Compensation –** expenses for treatment of an Injury or Sickness arising out of, or in the course of, employment for wage or profit; and expenses for treatment of Injury or Sickness for which the Insured Person has or had a right to recovery under any Workers' Compensation or similar Law.
13. **Excess Charges** – amounts above the Reasonable and Customary Charges for the services rendered by Out-of-Network Providers except as provided in the Policy.

14. **Experimental Treatment** – expenses related to services that are Experimental in nature.
15. **Family Members** – expenses related to treatment or services performed by a member of Your family or any person who regularly lives in Your home. Family members include You, Your spouse, Your spouse's parents, children, sisters, and brothers.
16. **Federal Facility** – expenses related to treatment, diagnosis, or care provided while confined in a federal facility, unless You are legally obligated to pay the charges for such confinement.
17. **Foreign Travel and Residency** – expenses related to treatment, drugs or medical care received outside the United States or its possessions, unless expenses are incurred to treat an Emergency Medical Condition while [on a trip] [of not more than 60 days].
18. **Growth Hormones** – expenses for treatment, medication or hormones intended to stimulate growth, unless Medically Necessary.
19. **Hearing Expenses** – expenses related to routine hearing exams to assess the need for, or change to, hearing aids; and the purchase, fittings or adjustments of hearing aids; and the surgical or non-surgical treatment for the improvement of hearing including, but not limited to, the insertion of hearing aids or implants; [beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits. Unless included in a Benefit Rider attached to this Certificate]
20. **Home HealthCare and Hospice Care** – expenses related to Home Health Care and Hospice Care beyond coverage already provided in Part 6 – Covered Charges and the Schedule of Benefits.
21. **Homeopathy**.
22. **Human Organ, Tissue and Bone Marrow Transplant Benefits** – expenses relating to, or arising from, Human Organ, Tissue and Bone Marrow Transplants beyond coverage provided in Part 6 – Covered Charges and the Schedule of Benefits.
23. **Hypnosis** – expenses related to hypnosis, including its use in place of anesthesia.
24. **Infertility** – expenses related to the treatment of infertility, reversal of voluntary sterilization, or fertilization procedures beyond the coverage provided in Part 6 – Covered Charges and on the Schedule of Benefits.
25. **Internet** – expenses related to treatment, diagnosis, or care provided over the Internet, or via electronic mail, unless such consultation or treatment qualifies as Telemedicine under California law.
26. **Liposuction** – expenses related to suction-assisted lipectomy or diastasis recti repair, including instances when diastasis recti repair is associated with an umbilical or ventral hernia.
27. **Manipulative Services** – beyond the benefit limits stated in Part 6 – Covered Charges and on the Schedule of Benefits.
28. **Mental Health Conditions -** beyond the benefit limits stated in Part 6 – Covered Charges and on the Schedule of Benefits.
29. **Non-Covered Charges** – expenses related to any benefit not specifically provided within the Policy and this Certificate.
30. **Non-Medical Expenses** – non-medical expenses, even if recommended by a Physician. This includes, but is not limited to: work hardening or strengthening programs; travel expenses; self-help training; services or supplies at a health spa or similar facility; a personal trainer; massage therapy; [elastic bandages]; [support hose]; shoes, shoe inserts, and [pressure garments]; personal hygiene and convenience items; water aerobics and cybex machines; television, telephone, cots and visitors' meals; charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form and information required to process Your claims and similar expenses.
31. **Outpatient Prescription Drugs** – beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
32. **Physical therapy, Occupational Therapy and speech therapy** – beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
33. **Pregnancy -** beyond the benefit limits stated in Part 6 – Covered Charges and on the Schedule of Benefits.
34. **Preventive Care Services –** beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
35. **Private Duty Nursing services** – except when such services are required for Home Health Care (see Part 6 – Covered Charges).
36. **Research** – expenses related to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research or clinical-research study.
37. **Robotic Assisted Surgery Services** [unless included in a Benefit Rider attached to this Certificate.]
38. **Routine physical examinations** – expenses related to routine physical examinations including immunizations, use of prophylactic injections including gammaglobulins and flu shots, and well-child care including immunizations except as specifically provided in Part 6 – Covered Charges and the Schedule of Benefits.
39. **Self-Harm** – expenses related to treatment of self-inflicted Injuries or Sicknesses or attempted suicide, whether sane or insane; except as a result of a medical condition.
40. **Sexual Dysfunctions** – expenses related to gender identity disorders, gender reassignment or sex transformation, [sexual dysfunctions or inadequacies]. This exclusion [includes][excludes] sexual therapy and

counseling, penile prosthesis and all other procedures, equipment and drugs developed for male impotency.[unless included in a Benefit Rider attached to this Certificate.]

41. **Substance Use** - beyond the benefit limits stated in Part 6 – Covered Charges and on the Schedule of Benefits.
42. **Take Home Prescription Drugs** – expenses relating to non-prescription drugs or any take home prescriptions.
43. **Travel Expenses** – beyond coverage already provided in Part 4 - Medical Management.
44. **Vision** – No benefits are payable for expenses related to
    A. Eye refractions or eye examinations, eye glasses or contact lenses beyond the benefit limits stated in Part 6 – Covered Charges is attached to the Schedule of Benefits. This exclusion does not apply to initial prosthetic lenses, or sclera shells following intra-ocular surgery.
    B. No benefits are payable for radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy, that are not performed in connection with an Injury or Sickness.[unless included in a Benefit Rider attached to this Certificate.]
45. **Voluntary Abortion** – except if the mother would have a Life-Threatening condition if the fetus were carried to term. [unless included in a Benefit Rider attached to this Certificate.]
46. **War** – expenses related to Injuries, Sicknesses, diseases or disorders as a result of war or act of war, declared or undeclared.
47. **Weight** – expenses related to weight reduction programs, weight management programs, related nutritional supplies, treatment for obesity, or surgery for removal of excess skin or fat.] [unless included in a Benefit Rider attached to this Certificate.]

PRE-EXISTING CONDITIONS LIMITATIONS

Coverage for an Insured Person is subject to the Pre-Existing Condition limitations which are as follows:

1. For Insured Persons who enroll during the Initial Enrollment Period or Special Enrollment Period, Covered Charges incurred for the treatment of Pre-Existing Conditions will not be covered under the Policy for a period of 6 months after the Enrollment Date. A Pregnancy will not be considered a Pre-Existing Condition; and
2. For Insured Persons who enroll outside an Initial Enrollment Period or Special Enrollment Period (Late Enrollees), Covered Charges incurred for the treatment of Pre-Existing Conditions will not be covered under the Policy for a period of 12 months after the Effective Date. A Pregnancy will not be considered a Pre-Existing Condition.

An Insured Person under the age of 19 will not be subject to the Pre-Existing Condition limitation.

Credit for Period of Previous Health Insurance

If on the date You enroll, You have Creditable Coverage that terminated no more than 63 days prior to Your Enrollment Date, You will be given credit for the full or partial satisfaction of the Pre-Existing Condition limitation period. Any period that You were in a Service Waiting Period prior to the effective date of Your coverage under the Policy will not be counted in determining whether You had a break in coverage that exceeded 63 days.

If You had 12 months of prior Creditable Coverage, the Pre-Existing Condition limitation period will be eliminated in its entirety. If You had less than 12 months of prior Creditable Coverage, the Pre-Existing Condition limitation period will be reduced by each month or partial month for which You had prior Creditable Coverage.

However, if Your coverage has ended for any of the reasons below, You will be credited with the time covered under Creditable Coverage if You become eligible for coverage under the Policy within 180 days, exclusive of any Service Waiting Period, and You apply for coverage under the Policy within the enrollment period:

A. Your employment has ended;
B. Your availability of health coverage offered through employment or sponsored by an employer has terminated; or
C. Your employer's contribution toward the individual's health coverage has terminated.

PART 8 – COORDINATION OF BENEFITS

Applicability

1. This Coordination of Benefit ("COB") provision applies to the Policy ("This Plan") when an Insured has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the order of benefit determination rules ("Rules") should be looked at first. Those Rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:
    A. shall not be reduced when, under the Rules, This Plan determines its benefits before another Plan; but
    B. may be reduced when, under the Rules, another Plan determines its benefits first.

Definitions

1. "Plan" is any of the following which provides benefits or services for, or on account of, medical or dental care or treatment:
   A. Group insurance or group-type coverage, whether insured or uninsured. This includes: prepayment, group practice or individual practice, coverage, and medical benefits coverage in group, group-type and individualautomobile "no-fault" and "traditional fault" type contracts. It does not include: student accident type coverage;
   B. Coverage under a governmental plan or required or provided by law. This does not include a Medi-Cal benefits under Chapter 7 (commencing with Section 14000 Welf. & Inst.) or Chapter 8 (commencing with Section 14500 Welf. & Inst.) of Part 3 of Division 9 of the Welfare and Institutions Code, or Medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 ofTitle 42 of the United States Code(as amended from time to time.) It also does not include any plan when, by law, its benefits are in excess of those of any private program or other non-governmental program.

   Each contract or other arrangement for coverage under A. or B. above is a separate Plan. Also, if an arrangement has two parts and COB rule applies only to one of the two, each of the parts is a separate Plan.

2. "This Plan" is the part of the Policy that provides benefits for health care expenses.

3. "PRIMARY PLAN"/"SECONDARY PLAN." The Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan: (a) may be a Primary Plan as to one or more other Plans; and (b) may be a Secondary Plan as to a different Plan or Plans.

4. "Allowable Expense." This means a Necessary, Reasonable, and Customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition. That is unless the patient's stay in a private Hospital room is Medically Necessary either: (a) in terms of generally accepted Medical practice; or (b) as precisely defined in the Plan.

   A Plan might provide benefits in the form of services. In this case the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

5. "Claim Determination Period." This means a Year. But, it does not include any part of a year: (a) during which a person has no coverage under This Plan; or (b) before the date this COB provision or a similar provision takes effect.

Effect on Benefits

1. When This Section Applies. This Section applies when This Plan is a Secondary Plan as to one or more Plans. In that case the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2. below.

2. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:
   A. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
   B. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

   exceed those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

   When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Order of Benefit Determination Rules

1. General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
   A. the other Plan has Rules coordinating its benefits with those of This Plan;

B. both those Rules and This Plan's Rules, in item 2 below, require that This Plan's benefits be determined before those of the other Plan.

2. Rules. This Plan decides its order of benefits using the first of the following rules which applies:

A. Non-Dependent/Dependent. The benefits of the Plan that covers the person, other than as a dependent, are determined before those of the Plan that covers the person as a dependent except that, if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

1) secondary to the Plan covering the person as a dependent; and

2) Primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

B. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph 2. c. below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":

1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

2) if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

However, the other Plan may not have the rule described above. Instead it may have a rule based upon the gender of the parent. If so, and if, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will decide the order of benefits.

C. Dependent Child/Separated or Divorced Parents. Two or more Plans may cover a person as a dependent child of divorced or separated parents. In this case benefits for the child are determined in this order:

1) first, the Plan of the parent with custody of the child;

2) the Plan of the spouse of the parent with the custody of the child; and finally

3) the Plan of the parent not having custody of the child.

However, the specific terms of a court decree might state that one of the parents is responsible for the health care expenses of the child. In this case if the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This item does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

D. Dependent Child/Joint Custody. If the court decree awards joint custody, then benefits are paid as in 2.b. above.

E. Active/Inactive Employee. The benefits of a Plan that covers a person as an employee who is neither laid off nor retired (nor as that employee's dependent) are determined before those of a Plan that covers that person as a laid off or retired employee (or as that employee's dependent.) The other Plan might not have this rule. If so, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

F. Longer/Shorter Length of Coverage. If none of the above rules decides the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter time.

G. Continuation Coverage: If a person whose coverage is provided under a right of continuation plan pursuant to federal or state law and also under this Plan, the following order of benefits applies:

1) First, the Plan covering the person as an employee, or as the employee’s dependent;

2) Second, the benefits of the continuation coverage.

If the other Plan does not have this rule and the Plans do not agree on the order of benefits, this rule is ignored.

Effect on the Benefits of this Plan

1. When This Section Applies. This Section applies when This Plan is a Secondary Plan as to one or more Plans. In that case the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2. below.

2. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

A. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

B. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceed those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information
Certain facts are needed to apply these COB rules. We have the right to decide which facts We need and to obtain them from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

Facility of Payment
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the forms of services. In such a case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
The amount of the payments made by Us might be more than We should have paid under this COB provision. In such a case, We may recover the excess from one or more of these:

1. Any persons to, or for whom, such payments are made; or
2. Any insurance companies; or
3. Any other organizations.

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services. The right of recovery does not include liability settlements. However, the right will not apply unless the Insured Person, whose loss is the basis for applying such provision, is made whole.

Any such right of reimbursement provided to Us under the Policy shall not apply or shall be limited to the extent that states or the state courts eliminate or restrict such rights.

Medicare Coordination
1. Claims will be coordinated with Medicare based on the Medicare Secondary Payor (MSP) Rules.
2. If the Insured Person is retired or on COBRA, Medicare is the Primary Plan and this Plan will be secondary for the Employee and the Employee's enrolled Dependents who are age 65 or over or eligible for Medicare because of disability. Medicare is considered a Plan for the purposes of Coordination of Benefits. The Plan will coordinate benefits with Medicare whether or not the Insured Person or the Insured Person's enrolled Dependents are actually receiving Medicare benefits.
3. The Plan is the Primary Plan and Medicare will be the Secondary Plan for an Employee and the Employee's enrolled Dependents during the first thirty (30) months in which the Employee or the Covered Dependent spouse or child(ren) is/are eligible for Medicare solely because of permanent kidney failure. After the first thirty (30) months, Medicare will be the Primary Plan and this Plan will be the Secondary Plan. Medicare will be considered a Plan for purposes of Coordination of Benefits. This Plan will coordinate benefits with Medicare whether or not the Insured Person or his Dependent spouse or child is/are actually receiving Medicare benefits.

PART 9 – PREMIUM PAYMENT

Payment Of Premium
Premiums are payable to Us. No insurance agent, insurance broker or insurance consultant is authorized to accept any premium payment on Our behalf. The Employer must timely pay the monthly premium in order to maintain the Policy. The payment of any premium will not keep the Policy in force beyond the due date of the next premium, except as provided in the Grace Period. If any premium is not received by Us before or at the end of the Grace Period, the Policy will automatically end at the end of the period for which the last premium payment has been paid.

Grace Period
The Employer is entitled to a grace period of 31 days for the payment of any Premium due except the first, during which grace period the Policy shall continue in force, unless the Employer has given the Company written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the Policy. The Employer shall be liable to the Company for the payment of a pro rata Premium for the time the coverage was in force during such grace period.

Premium Changes
We reserve the right to change premiums under the Policy on any premium due date by giving the Employer at least 31 days prior written notice.

If the Employer has selected a rate guarantee period when applying for coverage under the Policy, the premium will not change during the rate guarantee period except for the following reasons:

1. The addition or deletion of Employees to or from the coverage under the Policy;
2. An Employee enters into a new age rate-band;
3. The Employer changes the network to a network that is different than the network the Employer selected when applying for coverage;
4. The Employer moves to a different location from where the Employer was located at the time the Employer applied for coverage;
5. The Employer requests that coverage under the Policy be modified to increase or decrease benefits from those selected when applying for coverage; or
6. New state or federal statutes, rules or regulations become effective after the Effective Date of coverage and affect Our liability under the Policy.

PART 10 – RENEWABILITY AND TERMINATION

Renewability of the Policy
The Policy is on a monthly renewable basis at the option of the Employer, except for the following reasons:

1. Non-payment of the required premium;
2. Fraud or intentional misrepresentation of a material fact of or by the Employer, or with respect to coverage of an Insured, fraud or intentional misrepresentation of a material fact by the Insured or such person's representative;
3. For failure to comply with Policy provisions, including failure to provide proof, whenever requested by Us, that the Employer is complying with the Employee contribution and participation requirements;
4. For not maintaining Employee participation requirements for at least six consecutive months ;
5. For not maintaining Employee contribution requirements;
6. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would not be in the best interests of the Policyholder or certificateholders;
7. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would impair Our ability to meet Our obligations;
8. The type of coverage under the Policy is no longer offered by Us in the state of the Employer's residence in which event We will provide ninety (90) days prior written notice of the discontinuance and We will offer the Employer the option to purchase any other health insurance coverage currently being offered by Us to employers in the large group market in that state.
9. We decide to discontinue offering all health insurance in the large group market in the state of the Employer's residence in which event We will provide the applicable State authorities and the Employer written notice 180 days prior to the discontinuation and We will discontinue all health insurance issued or issued for delivery in the large group market in the state of the Employer's residence and will not renew such coverage in the state of the Employer's residence.

Time For Non-Renewal of the Policy
All insurance under the Policy for an Employer, its Employees and their Dependents shall be non-renewed as follows:

1. Lapse due to non-payment of premium, at 12:01 A. M., of the premium due date following the end of the month for which the last premium payment is made on account of the Employer's insurance; or
2. Non-renewal for all other reasons, at 12:01 A. M., of the premium due date coinciding with or next following the date such event took place.

Termination Of Employee's Coverage
Coverage for an Insured Employee shall automatically terminate on the earliest of the following dates:

1. The date of termination of the Policy; or

2. The date of termination of any section or part of the Policy with respect to insurance under such section or part; or

3. The [last] day of the month in which You no longer meet the eligibility criteria established in the Policy; or as outlined on Your Schedule of Benefits.

4. The date You or Your Employer fails to pay the required premium; or

5. The date You enter the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided under the Statement of Uniform Services Employment and Reemployment Rights Act of 1994 provision; or

6. The date the Policy is amended to terminate the eligibility of any class of [Retiree][Part-time Employee][tribal member][officer][partner][or [director] of which the [Retiree] [Part-time Employee] [tribal member] [officer][partner]or [director] is a member.

Termination Of Dependent Insurance

Coverage for an Insured Employee with respect to Dependents shall terminate on the earliest of the following dates:

1. The date of termination of the Policy; or

2. The date of termination of any section or part of the Policy in respect to insurance under such section or part; or

3. The date Your insurance terminates; or

4. The date You or Your Employer fails to pay the required premium; or

5. The dayof the Policy Month in which a Dependent ceases to meet the definition of "Dependent"; or

6. The date the Dependent enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided by the Statement of Uniform Services Employment and Reemployment Rights Act of 1994 provision; or

7. With respect to an Insured Employee's Dependent spouse, the premium due date coinciding with or next following the date on which the Insured Employee is divorced or legally separated from such spouse; or

8. The premium due date coinciding with or next following the date on which a Dependent child no longer qualifies under the definition of “Dependent.” If upon attaining any limiting age specified in the Schedule of Benefits, a Dependent child, because of Mental or Physical Incapacity, as defined below, is incapable of earning his or her own living and is chiefly Dependent upon the Insured Person for support and maintenance, coverage for the Dependent child may be continued during the continuance of such incapacity, providing that:

   A. Medical proof, in writing, of such incapacity must be given to Us within 31 days after the date on which the Dependent child attains a limiting age; and

   B. We shall have the right any time during the continuance of insurance under this provision to require due proof of the continuance of the incapacity and to have the Dependent child examined by Physicians designated by Us at any time during the first 2 years of such continuance and not more than once each year thereafter; and

   C. You continue paying the required premium for the Dependent; and

   D. The continuance described herein shall cease in the event of the occurrence of any of the circumstances described in paragraphs 1. through 8. above.

   For the purposes of the provision, the following definition applies:

   Mental or Physical Incapacity means a mental or physical impairment that results in anatomical, physiological or psychological abnormalities which are demonstrated by medically acceptable clinical, laboratory or diagnostic techniques and which are expected to last for a continuous period of time not less than 12 months in duration.

Modifications

We may modify the Policy and this Certificate if the modification occurs at the time of coverage renewal.

Medical Insurance Conversion Privilege

If an Employee’s insurance terminates after at least three (3) consecutive months of coverage under that Part due to termination of employment or termination of membership in the class(es) eligible for insurance under the Policy, and that termination of insurance occurs prior to the Employee’s sixty-fifth (65th) birthday, the Employee shall be entitled to have an individual policy or certificate (herein referred to as the “converted policy”) of medical expense insurance issued to him by Us, without having to furnish evidence of insurability, and subject to the following conditions:

1. Written application and payment of the first premium for the converted policy must be made to Us no later than sixty-three (63) days after such termination of coverage;

2. The converted policy shall be effective on the date immediately following termination of the Employee's insurance under the Policy;
3. The converted policy may also cover the Employee's Dependents, if any, who were insured under the Policy at the time of such termination. At Our option, a separate converted policy may be issued to cover any of the Employee's Dependents;
4. The converted policy shall be determined in accordance with the benefits provided under the most popular preferred provider organization plan as determined by the Department of Managed Health Care;
5. The converted policy shall be upon one of the forms then customarily issued by Us at the time application is made; and
6. The premium for the converted policy shall be based on the Insurance Company's then customary rate applicable to the form of the converted policy, to the amount of benefits, to the sex of the person, to the class of risk to which that person then belongs, and to his age on the effective date of the converted policy.

Provided, however, that We shall not be required to issue a converted policy covering any person, if that person is or could be covered by Medicare.

Furthermore, We shall not be required to issue a converted policy covering any person if: (1) that person is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act; or (2) that person is covered by or eligible for hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured; or (3) the person is covered for similar benefits by an individual policy or contract; or (4) the person has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

PART 11 – GENERAL PROVISIONS

Entire Contract - Changes

The entire contract is made up of: (a) the Policy; (b) the Employer's Application; and (c) any individual Employee Applications. No agent, Employer, Employee, or other individual, except Our President, Vice President, Secretary or Assistant Secretary can: (a) approve a change to the Policy; or (b) extend the time for payment of any premium. No change will be valid unless it is made: (a) by an Endorsement or Rider to the Policy; or (b) by an Amendment signed by Our President, Vice President, Secretary or Assistant Secretary. Any change made will be binding on each Insured Person and on any other individual(s) referred to in the Policy and this Certificate.

Incontestability

The validity of the Policy will not be contested, except for non-payment of premiums, after it has been in force for 2 years from the Date of Issue.

In the absence of fraud, a statement made by any individual covered by the policy relating to the individual's insurability may not be used in contesting the validity of the insurance with respect to which the statement was made: (a) after the insurance has been in force before the contest for two years during the individual's lifetime; and (b) unless the statement is contained in a written instrument signed by the individual making the statement.

Representations

In the absence of fraud, a statement made by the Policyholder or an Insured Person is considered a representation and not a warranty; and a statement made by the Policyholder or an Insured Person may not be used in any contest under the Policy, unless a copy of the written instrument containing the statement is or has been provided to: (a) the person making the statement or (b) if the statement was made by the Insured Person and the Insured Person has died or become incapacitated, the Insured Person's beneficiary or personal representative.

Conformity with Federal and State Laws

Any provision of the Policy which is in conflict with Federal laws or any applicable state law is hereby amended to meet the minimum requirements of the law.

Ambiguities

Any terms or conditions specified in the Policy that are determined to be ambiguous or in conflict with State or Federal laws shall be considered separately and shall not void or effect the legality of the remaining terms and conditions that are included in the Policy and this Certificate.

Physical Examination

We have the right, at Our own expense, to have an Insured Person for whom claim Is made examined as often as is reasonable while a claim is pending under the Policy.

Workers' Compensation
The Policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

Certificates/Booklets
We will issue to the Employer a Certificate for delivery to each Insured Employee.

Waiver Of Rights
If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date; nor will it affect Our right to enforce any other provision of the Policy. Any waiver of rights must be in writing and signed by Our President, Vice President Secretary or Assistant Secretary or an individual authorized by them to agree to such waiver.

Required Information
The Insured Person agrees to provide to Us any information or data that we reasonably request for the proper administration of the Policy including; but not limited to, information pertaining to medical history, medical records, the names of all health care Providers from whom the Insured Person has received treatment or services, documentation of prior Creditable Coverage, marriage license, documentation of adoption, documentation of legal custody of a Dependent, student status information, and treating Provider statements.

Effective Date
No insurance under the Policy shall become effective until notice in writing is given to the Employer by Us. Issuance of a Certificate with a Validation of Coverage face page will be deemed proper notification, provided premium due has been paid in accordance with the terms of the Policy.

Misstatement of Age
If the age of an Insured Person has been misstated, We will make an equitable adjustment of premiums or benefits or both. We will change the benefit to the applicable amount available for the correct age. We will refund to the Employer any excess premium paid over the amount due for the correct benefit amount. We will request payment for any overdue premium for the correct benefit amount.

PART 12 – CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to Us as soon as possible. Written notice of claim given by or on behalf of the Insured to Us with information sufficient to identify such person will be considered notice to Us.

Claim Forms: Upon receipt of written notice of claim, We will furnish the required forms (if any) for filing proof of loss. If We do not send the forms within 15 days, You can satisfy Our requirements by giving Us a written statement. The statement should include the nature and extent of the claim, and be sent to Us in accordance with the proof of loss provision.

Proof of Loss: Written proof of loss must be furnished to Us within 90 days after the date the medical treatment was received. Written proof of loss includes all information necessary for Us to determine that a valid loss occurred. If it is shown that it is not reasonably possible to furnish written proof of loss within that time, the claim will not be rejected or reduced as long as We receive such proof as soon as reasonably possible, and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required pursuant to this provision.

Timely Payment of Claims: We will pay all benefits due for Covered Charges, promptly upon receipt of due proof of loss. We will pay or deny benefits within 30 business days of receipt of due written proof of loss, or if due written proof of loss is not received with a claim, We will contest the claim within 30 business days of its receipt. If We fail to pay, deny or contest within those time periods, We will pay interest on any benefits payable at the rate of 10 percent per annum beginning on the first calendar day after the 30 business day period.

Assignment of Claims: All benefits payable will be payable to You unless a written assignment of benefits is filed with Us at Our administrative office. We will not be responsible for the legal effect of any assignment.

Payment of Claims: All benefits for Covered Charges are payable to You unless You have otherwise assigned the benefits to a medical Provider. If any such benefits remain unpaid at Your death, or, if You are, in the opinion of the Company, incapable of giving a legally binding receipt for payment of any benefit, We may, at Our option, pay such benefit to any one or more of the following relatives: Your spouse, mother, father, child, brother or sister. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment.

If any such benefits are payable to the estate of the Insured Person, or if the Insured Person is a minor or is, in our opinion, legally incapable of giving valid receipt and discharge of any payment, We may, at Our option, pay an amount not

exceeding $1,000.00 to any relative by blood or marriage of the Insured Person or beneficiary, who is considered by Us to be equitably entitled thereto. Any payment so made will constitute a complete discharge of Our obligations to the extent of that payment, and We will not be required to see to the application of the money so paid.

Right to Appeal
You or Your Authorized Representative have the right to appeal any decision or action taken by Us to deny, reduce or terminate the provision of or payment for health care services requested or received under the Policy. When We have denied, reduced or terminated a requested service or payment for a service covered by the Policy based on a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care services, You or Your Authorized Representative have the right to have Our decision reviewed by an independent review organization not associated with Us.

We will provide You or Your Authorized Representative with certain written information, including the specific reason for Our decision and a description of Your appeal rights and procedures every time We make a determination to deny, reduce or terminate the provision of or payment for health care services requested or received under the Policy.

For the purpose of this provision, the following definition applies:
Authorized Representative means a person to whom an Insured Person has given consent to represent the Insured Person in an external review. Authorized Representative may include the Insured Person's treating Provider.

Legal Action
No action at law or in equity will be brought to recover under the Group Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Group Policy, nor will any action be brought after 3 years from the date the claim was first incurred.

Recovery of Overpayments
We reserve the right to deduct from any future benefits payable under the Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or intentional misrepresentation of a material fact made to obtain coverage under the Policy within 2 years after the Effective Date; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any policy or act of law providing coverage for occupational Injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by an Insured Person if claim payments previously were made with respect to such Insured Person.

Subrogation/Right Of Reimbursement
As a condition to receiving benefits under this Policy, Insured Person(s) agree to transfer to Us their right to recover damages to the extent of benefits paid by Us when an Injury or Sickness occurs through the act or omission of another person. If an Insured Person received payment from another person or entity on account of, due to, or arising out of an Injury or Sickness, the Insured Person agrees to reimburse Us to the full extent of Covered Charges paid. If a repayment agreement is required to be signed, all rights of recovery are transferred to Us regardless of whether it is actually signed. It is only necessary that the Injury or Sickness occur through the act or omission of another person or entity. Our rights of full recovery may be from any other person or entity, any liability or other insurance covering such other person or entity party, the Insured Person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault, workers compensation or school insurance coverages which are paid or payable. We may enforce Our reimbursement rights by requiring the Insured Person to assert a claim to any of the foregoing coverages to which the Insured Person may be entitled. Insured Person(s) shall provide all requested accident and insurance information to Us. We shall not be required to pay any portion of Insured Person's attorneys' fees or other costs associated with a claim/lawsuit.

PART 13 - GRIEVANCE RIGHTS AND PROCEDURES

Claim Inquiries: Please contact Our Customer Service Department at [1-800-123-4567] with any questions about the processing of Your claim, including coverage and benefit determinations and Grievance Reviews.

Grievance Reviews: If You disagree with a coverage or benefit determination, You have the right to file a Grievance about that determination within 180 calendar days from the date You received the coverage or benefit determination.

Grievance Review Instructions and Procedures:

1. To submit a Grievance, please
   a. State Your request for a Grievance review in writing, include Your full name, date of birth and certificate number, identify the claim in question, and explain why You disagree with the determination. You may also submit any additional written comments, documents, records or other information relating to the claim.
   b. Sign and date Your written request and attach all supporting documentation.
   c. Mail the written request and attachments to the following address, within the 180-day deadline stated above:

[Claims Dept, Attn: Grievance Reviews
Sterling Life Insurance Company
Address, city, state zip]

2. Upon request and at no charge, You may have reasonable access (including copies) to all documents, records and information submitted to Our office that relates to Your claim, including clinical rationale or review criteria.
3. The Grievance review will take into account all written comments, documents, records and other information submitted to Our office that relate to Your claim, including such comments, documents, records or other information not previously considered or not submitted at the time the claim was processed.
4. The Grievance review will be a "fresh" look at Your claim, ignoring the appealed determination. It will be conducted by a person not involved in the appealed determination and not supervised by someone involved in that determination.
5. If the appealed determination is based on a medical judgment (in whole or in part), the Grievance review will include consultation with a health care professional, trained and experienced in the medical field relevant to the determination, not involved in the appealed determination and not supervised by someone involved in that determination.
6. You or Your Physician may request a Grievance review, and You may be represented by a relative, friend or lawyer.
7. Within 5 business days of receiving Your written request, Our office will mail a written acknowledgement to You.
8. Within 30 calendar days of receiving Your written request, Our office will mail a written determination to You.

Additional Grievance Review Available:

1. If You disagree with the Grievance review determination, You may voluntarily request a second Grievance review. To exercise this second and final right to file a Grievance, You must submit another written request for a Grievance review to Our office within 180 calendar days from the date You received the determination for the first Grievance review. Please refer to the Grievance review instructions and procedures stated above for completing and submitting a written request for a second Grievance review. NOTE: A SECOND GRIEVANCE REVIEW IS COMPLETELY VOLUNTARY AND IS NOT NECESSARY IN ORDER TO EXHAUST ALL ADMINISTRATIVE RIGHTS OF APPEAL UNDER THE POLICY OR TO REQUEST AN INDEPENDENT MEDICAL REVIEW.
2. If You disagree with any Grievance review determination (first or second), You have a right under California state law to request an Independent Medical Review of Your claim. Our office will mail written notice of that right (see below) on or before Our receipt of Your initial request for a Grievance review, and an application form will be enclosed with each Grievance review determination. Strict time limits within which to request an Independent Medical Review apply.

State Assistance:

You have the right to request assistance from, or to file a complaint with, the California Department of Insurance at any time. Please note the following contact information:

[California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street, South Tower, Los Angeles CA 90013
800-927-HELP (in CA),
213- 897-8921 (outside CA)].

Judicial Review:

If You disagree with a Grievance review determination, You have the right to bring a civil action under California state law (if benefits have been denied based on Medical Necessity, You must first exhaust all rights to an Independent Medical

Review under California state law). The time limitations stated in this Certificate for bringing legal actions or proceedings apply to any such civil action.

NOTICE OF RIGHT TO AN INDEPENDENT MEDICAL REVIEW

This NOTICE contains important information about Your insurance claim and Your RIGHT TO SEEK INDEPENDENT MEDICAL REVIEW of the coverage or benefit determination. Please carefully read the following instructions on how to request an Independent Medical Review, pursuant to California law. If You have any questions about submitting Your written request, please call Our Customer Service Department at [1-800-123-4567].

IMPORTANT: You must submit Your request within the time period explained below.

Independent Medical Review Process

A. Eligibility

You may apply to the Independent Medical Review System if:

- You are a resident of California;
- Benefits have been denied, modified or delayed (in whole or in part) for any health care service, due to a finding that the service is not Medically Necessary ("Disputed Health Care Service");
- The denial of benefits is not substantially based on a finding that provision of the health care services is excluded from coverage under the terms and conditions of the Policy ("Coverage Decision");
- You have completed the Grievance review process and You contest the determination (or Your grievance remains unresolved and it was submitted more than 30 days ago); and
- It has been no more than 6 months since You received the Grievance review determination (or, if Your Grievance remains unresolved, no more than 6 months and 30 days since You submitted the Grievance). The Commissioner of the California Department of Insurance may extend the application deadline if warranted by circumstances.

B. Application and Fees

If You are eligible to obtain an Independent Medical Review, You may apply by completing the application form and using the addressed envelope enclosed with the Grievance review determination, or by mailing a written request to either the:

[California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street, South Tower
Los Angeles CA 90013
800-927-HELP (in CA)
213- 897-8921 (outside CA)]

or, the following address (upon receipt, the request will be forwarded to the California Department of Insurance):

[Claims Dept, Attn: Grievance Reviews
Sterling Life Insurance Company
Address, city, state zip]

There are no application or review fees or charges for You to pay.

C. Review Procedures

The California Department of Insurance will, at the time of the receipt of the request for an Independent Medical Review, assign an Independent Medical Review Organization (IMRO) from the list of certified IMROs and will so inform the insurer.

If the request for an Independent Medical Review is not based on a Disputed Health Care Service, but on a Coverage Decision, the California Department of Insurance will instead conduct the review. If there is ambiguity as to what entity should conduct the review, the review will be conducted by an IMRO.

Within 3 business days after the date on which We receive notice of the IMRO from the California Department of Insurance, We will provide to the assigned IMRO all documents and information utilized in making the Disputed Health Care Service, as well as the final written decision from the insurer, including:

- A copy of all of Your medical records in Our possession relevant to Your medical condition, the health care services being provided for that condition, and the Disputed Health Care Services.
- Any newly developed or discovered relevant medical records in Our possession after the initial documents are provided to the IMRO shall be forwarded immediately to the IMRO independent medical review, with copies forwarded to You (or Your provider, if authorized by You), unless declined or otherwise prohibited by law.
- A copy of all information provided to You by Us concerning Our and Your provider decisions regarding Your condition and care, and a copy of any materials You or Your provider submitted to Us in support of Your request for the Disputed Health Care Services. This documentation shall include the Grievance review determination.
- A copy of any other relevant documents or information used by Us in determining whether the Disputed Health Care Services should have been provided, and any statements by Us explaining the reasons for the decision to deny benefits for the Disputed Health Care Services on the basis of Medical Necessity, with copies forwarded to You (or Your provider, if authorized by You), unless declined, prohibited by law, or the Commissioner of the California Department of Insurance determines it to be legally privileged information.

The California Department of Insurance and the IMRO shall maintain the confidentiality of any information found by the Commissioner to be proprietary information of Ours and the confidentiality of all Your medical record information shall be maintained pursuant to applicable state and federal laws.

D. Confidentiality

Your medical records provided to Us and the IMRO and the findings and recommendations of the IMRO are confidential and will be used only by the California Department of Insurance, the IMRO, and Us. The medical records and findings and determinations will not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate and will not be included under any materials available to public inspection.

We may at any time determine to provide the requested medical services by so notifying the IMRO or the California Department of Insurance, and You. Such notification will terminate the Independent Medical Review process.

Preventive Care Services, Manipulative Services, TMJ, Infertility, Nicotine Use and Acupuncture Services must be received from an In-Network Provider or benefits will be denied.

SLIC NOTCA 511

SCHEDULE OF BENEFITS / ***[Options are in Brackets]***

Policyholder:
Employer:
Required Hours:
Insured:
Certificate Number:
Effective Date:
Premium Due Date: [1st of the month][15th of the month]
Schedule Date:
Domestic Partner Coverage: [Yes/No]
Dependent Spouse:
Dependent Child(ren): [Child(ren) Name(s)]
Dependent Limiting Age: [up to 26-99]
Student Eligibility Limiting Age: [26-99]
Pre-Existing Conditions Limitations Apply: [Yes/No][Does not apply to Insured Persons less that than age 19-99]
[Health Care Reform Status][-][Non-Grandfathered][Grandfathered]
Year: [Calendar] [Plan] Year
[All services, except for Emergency Services, must be received from an Exclusive Provider or benefits will be denied.]

Medical Expense Benefits

Covered Services per	In-Network Cost to Covered Person	Out-of-Network Cost to Covered Person
Deductible per Year [(1)]		
Individual	[$0 - $10,000] [[Benefit Allowance of first [$0-$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable]	[[2X][3X] In-Network]] [$0 - $20,000] [[Benefit Allowance of first [$0-$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable]
Family	[Embedded][Aggregate] [[2X][3X] individual] [$0 - $20,000] [[Benefit Allowance of first [$0-$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable] [Two][Three][Individuals must each meet their Individual Deductible to satisfy Family Deductible]	[Embedded][Aggregate] [[2X][3X] In-Network]] [$0 - $40,000] [[Benefit Allowance of first [$0-$5000] will be covered at 100%][Does not apply to Copays or Prescription Benefits]][Covered Person's annual Deductible/Coinsurance will then be applicable] [Two][Three][Individuals must each meet their Individual Deductible to satisfy Family Deductible]
Coinsurance for all Eligible Expenses	[0% - 50%]	[0% - 50%]
Out-of-pocket Maximum (OOP)[(2)(3)]		
Individual	[$0 - $10,000]	[[2X][3X] In-Network]] [$0 - $150,000]
Family	[2X][3X] individual] [$0 - $20,000] [Two][Three][Individuals must each meet their Individual Out-of-Pocket to satisfy Family Out-	[[2X][3X] In-Network]] [$0 - 250,000] [Two][Three][Individuals must each meet their Individual Out-of-Pocket to

	of-Pocket]	satisfy Family Out-of-Pocket]
Deductible Applies Coinsurance Applies Copayment Applies Out-of-Network Deductible & OOP apply to In-Network Deductible & OOP	[Yes, No] [Yes, No] [Yes, No] [Yes, No]	
Maximum per year:	[Embedded][Aggregate] [Not Applicable] [For [Calendar][Plan] Years beginning before [September 23, 2011] $750,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2011] but before [September 23, 2012] $1,250,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2012] but before [January 1, 2014] $2,000,000] [Effective [January 1, 2014] there is no [Calendar][Plan] Year Maximum Benefit for Essential Health Benefits]]	[Embedded][Aggregate] [Not Applicable] [For [Calendar][Plan] Years beginning before [September 23, 2011] $750,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2011] but before [September 23, 2012] $1,250,000] [For [Calendar][Plan] Years beginning on and after [September 23, 2012] but before [January 1, 2014] $2,000,000] [Effective [January 1, 2014] there is no [Calendar][Plan] Year Maximum Benefit for Essential Health Benefits]]
Covered Services per	**In-Network Cost to Covered Person**	**Out-of-Network Cost to Covered Person**
Physician Care • [Office Visit]	[General Practitioner] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Specialist] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[General Practitioner] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage] [Specialist] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
• [Lab Tests & X-rays]	[Major] [Specialty Diagnostic Services] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Minor] [Diagnostic Testing Services] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Major] [Specialty Diagnostic Services] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage] [Minor] [Diagnostic Testing Services] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%]
• [Office Surgery]	[Major] [Surgical & Endoscopic Services over $[350-$1000]] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Minor]	[Major] [Surgical & Endoscopic Services over [$350- $1000]] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage] [Minor]

	[Surgical & Endoscopic Services under [$350-$1000]] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Surgical & Endoscopic Services under [$350- $1000]] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]

• [Allergy Injections]	[Copay] [$0-$500][[*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Preventive Care Services] .]	[Covered at 100%]	[No Coverage] [Copay][$0 - $500][*][then][deductible][coinsurance] [No coverage]
Comprehensive Preventive Care for Dependent children 18 years of age and younger	[Copay] [$0-$500][[*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
Cancer Screening Test including Pap Smear, Mammography, Prostate Specific Antigen Testing, and Colorectal Cancer Screening	[Copay] [$0-$500][[*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
[Vision Exam – Routine	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$50 - $1,000]] [Limited to max benefit of [1] visit[s]][every [[1]] [[2]] [year][s]	
[Hearing Exam – Routine	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$50 - $1,000]] [Limited to max benefit of [1] visit[s]] [every [[1]] [[2]] [year][s]	
Emergency Services • [Urgent Care]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
• [Emergency Room ([Copay] waived if admitted)]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
Ambulance • [Ground]	[Copay] [$0-$10000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$10000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]

• [Air]	[Copay] [$0-$20000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$20000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
Pregnancy/Maternity Care • **[**Office Visit (pre & postnatal)]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
• [Hospitalization]	**[Routine Newborn – Split [(Mother/Newborn)]** Copay [$0-$1000]][*] [Daily Copay [$0-$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$5,000] [deductible/coinsurance] [no coverage]	**[Routine Newborn – Split][(Mother/Newborn)]** Copay [$0-$2000]][*] [Daily Copay [$0-$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$10,000] [deductible/coinsurance] [no coverage]
[Elective Sterilization]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]
Hospitalization Inpatient Services • [Semi-private Hospital Room & Board]	[Copay] [$0-$1000]][*] [Daily Copay [$0-$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$5,000] [deductible/coinsurance]	[Copay[[$0-$2000]][*] [Daily Copay [$0-$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$10,000]] [deductible/coinsurance] [No coverage]
• [Physician & Surgeon Services]	[Copay [$0-$1000]][*] [Daily Copay [$0-$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$5,000]] [deductible/coinsurance] [Specialist Services] [Copay [$0-$1000]][*] [Daily Copay [$0-$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$5,000]] [deductible/coinsurance]	[Copay[[$0-$2000]][*] [Daily Copay [$0-$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$10,000]] [deductible/coinsurance] [No coverage] [Specialist Services] [Copay[[$0-$2000]][*] [Daily Copay [$0-$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$10,000]] [deductible/coinsurance] [No coverage]
• [Lab, X-ray and other facility charges]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%]

		[No coverage]
Hospital Outpatient Surgery	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
Hospital Outpatient Services	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
Mental Health Conditions		
• [Inpatient]	[Copay] [$0-$1000]][*] [Daily Copay [$0-$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$5,000] [deductible/coinsurance] [no coverage]	[Copay[[$0-$2000]][*] [Daily Copay [$0-$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$10,000] [deductible/coinsurance] [no coverage]
• [Outpatient /Transitional Care]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]
• [Office Visit]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]
Severe Mental Illness	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
Serious Emotional Disturbances of a Child	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
Substance Use Disorders		
• [Inpatient]	[Copay] [$0-$1000]][*] [Daily Copay [$0-$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$5,000] [deductible/coinsurance] [no coverage]	[Copay[[$0-$2000]][*] [Daily Copay [$0-$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$10,000] [deductible/coinsurance] [no coverage]
• [Outpatient /Transitional Care]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%][no coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%][no coverage]
• [Office Visit]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [no coverage]

Rehabilitation Services		
• [Inpatient]	[Copay] [$0-$1000]][*] [Daily Copay [$0-$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$5,000] [deductible/coinsurance]	[Copay[[$0-$2000]][*] [Daily Copay [$0-$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$10,000] [deductible/coinsurance] [No coverage]
• [Outpatient]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Physical] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Speech] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [Occupational] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [Physical] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [Speech] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [Occupational] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
	[(Limited to [Calendar][Plan] Year maximum benefit of [10 – 365 visits][maximum visits by therapy type]	
	[(Limited to [Calendar][Plan] Year maximum benefit of [$2,500 – $20,000]	

Durable Medical Equipment	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$2,500 – $10,000]	
	[Rental limited to purchase price]	
Skilled Nursing Facility	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [10 – 365 days]	
Home Health Care	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [10 – 365 visits] or [$0-5,000]]	
Hospice and Respite Care Services	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of $500 - $10,000, Not Applicable]	
Organ Transplant	[Copay] [$0-$1000]][*] [Daily Copay [$0-$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement	[Copay[[$0-$2000]][*] [Daily Copay [$0-$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No

	[No Limit] [$0-$10,000] [deductible/coinsurance] [Donor Fees for Covered Organ Transplant] [Copay] [$0-$1000]][*] [Daily Copay [$0-$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$10,000] [deductible/coinsurance]	Limit] [$0-$20,000] [deductible/coinsurance] [Donor Fees for Covered Organ Transplant] [Copay[[$0-$2000]][*] [Daily Copay [$0-$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$20,000] [deductible/coinsurance] [No coverage]
	[Limited to [Lifetime][Per Transplant] maximum benefit of[$20000 - $100000] [Not Applicable]	
Manipulative Services	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$500 - $5,000]]	
	[Limited to max per Year benefit of [10 - 40 visits]	
[Temporomandibular Joint Dysfunction (TMJ)]	[Non-Surgical] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage] [Surgical] [Copay] [$0-$1000]][*] [Daily Copay [$0-$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$5,000] [deductible/coinsurance] [No coverage]	[Non-Surgical] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage] [Surgical] [Copay[[$0-$2000]][*] [Daily Copay [$0-$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$10,000] [deductible/coinsurance] [No coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$500 - $5,000]]	
	[Limited to max per Year benefit of [20 visits]	
[Infertility]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$500 - $25,000]]	
	[Limited to max per Year benefit of [20 visits]]	

Nicotine Use	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
[Acupressure/Acupuncture]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]

	[Limited to [Calendar][Plan] Year maximum benefit of [$500 - $5,000]]	
	[Limited to max per Year benefit of [10 - 40 visits]	
[Autism Spectrum Disorder]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$500 - $5,000]]	
	[Limited to max per Year benefit of [10 - 40 visits]	
OPTIONAL BENEFITS		
[Bariatric Surgery]	[Copay] [$0-$1000]][*] [Daily Copay [$0-$1000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$5,000] [deductible/coinsurance] [no coverage]	[Copay[[$0-$2000]][*] [Daily Copay [$0-$2000]] [Maximum number of days per confinement to which the Copay applies [0-31 days] [Maximum Copay per confinement [No Limit] [$0-$10,000]] [deductible/coinsurance] [no coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$5000 - $10,000]]	
[Cochlear Implants]	[Copay $0 – $5,000] [*] [[Covered at [0%-100%]] [deductible] [coinsurance][No Coverage]	[Copay $0-$10,000][*][deductible] [coinsurance] [No Coverage]
	[Limited to Year maximum benefit of ($0 - $30,000)]	
	[Limited to a maximum per lifetime benefit of [$0 - $100,000]]	
[Health Education Programs]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Health Education Asthma] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Dietetic Counseling for Anorexia, Bulimia and Polyphagia] [Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Health Education Asthma] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage] [Dietetic Counseling for Anorexia, Bulimia and Polyphagia] [Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$0 - $5,000]]	
[Hearing Aids]	[Copay $0 – $1,000] [*] [Covered at [0%-100%]] [deductible] [coinsurance][No Coverage]	[Copay $0-$2,000][*][deductible] [coinsurance] [No Coverage]
[Impacted Wisdom Teeth Removal]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Orthotics]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$100 - $5,000]]	
[Prosthesis]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$100 - $5,000]]	

	[Limited to [Calendar][Plan] Year maximum benefit of [$500 - $25,000]]	
[Sexual Dysfunction]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Limited to [Calendar][Plan] Year maximum benefit of [$100 - $5,000]]	
[Supplemental Accident Benefit]	Limited to Year maximum benefit of [$100-$2000]	

[Teeth Bleaching Following Accident]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
[Voluntary Abortion]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Limited to a max [1][2] [Year] benefit of[1]	
[Weight Management]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]

Injectible & Specialty Medications [Paid under Major Medical Benefits]	[Copay] [$0-$500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Copay] [$0-$1000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Generic] [Copay] [$0-$1,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Generic] [Copay] [$0-$2,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Brand Preferred][Copay] [$0-$2,500] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Brand Preferred] [Copay] [$0-$5,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]
	[Brand Non-Preferred] [Copay] [$0-$5,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]	[Brand Non-Preferred] [Copay] [$0-$10,000] [*][then] [deductible][coinsurance] [Covered at 100%] [No Coverage]

[Prescription Drug]	[deductible] [coinsurance] [Not Covered] [Does not apply to medical][deductible][&][out-of-pocket maximum]][Does apply to medical deductible & out-of pocket maximum]
[RX Deductible]	[Not Applicable][$0 - $10,000]
[Per Individual]	[[$0 - $5,000] per Year]]
[Per Family]	[$0 - $10,000] per Year]]
[Prescription Out-of-Pocket Maximum]	[Not Applicable][$0 - $20,000]
[Per Individual]	[[$0 - $10,000] per Year]]
[Per Family]	[$0 - $20,000] per Year]]
[Prescription Contraceptive Coverage]	
• [Drugs]	[Minimum][Maximum][Copay [($0 - $500)][deductible] [coinsurance] [Not Covered]
• [Devices]	[Minimum][Maximum][Copay [($0 - $500)][deductible] [coinsurance] [Not Covered]
Retail –	**[[30-90] day supply]**
- [Generic]	[Minimum][Maximum][Copay [($0 - $500)][deductible] [coinsurance] [Not Covered]
-[Brand Preferred]	[Minimum][Maximum][[Copay [($0 - $1,000)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][[Copay [($0 - $2,000)][deductible] [coinsurance] [Not Covered]
• [Preventive Drug]	
- [Generic]	[Minimum][Maximum][[Copay [($0 - $100)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][[Copay [($0 - $150)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][[Copay [($0 - $200)][deductible] [coinsurance] [Not Covered]

• [Injectible & Specialty Medications]	
- [Generic]	[Minimum][Maximum][[Copay [($0 - $1,000)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][[Copay [($0 - $2,000)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][[Copay [($0 - $3,000)][deductible] [coinsurance] [Not Covered]
Mail Order	**[[90-100] day supply]**
- [Generic]	[Minimum][Maximum][[Copay [($0 - $1,500)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][[Copay [($0 - $3,000)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][[Copay [($0 - $6,000)][deductible] [coinsurance] [Not Covered]

• [Preventive Drug]	
- [Generic]	[Minimum][Maximum][[Copay [($0 - $100)][deductible] [coinsurance] [Not Covered]
- [Brand Preferred]	[Minimum][Maximum][[Copay [($0 - $150)][deductible] [coinsurance] [Not Covered]
- [Brand Non-Preferred]	[Minimum][Maximum][[Copay [($0 - $200)][deductible] [coinsurance] [Not Covered]
• [Injectible & Specialty Medications]	
• [Generic]	[Minimum][Maximum][[Copay [($0 - $3,000)][deductible] [coinsurance] [Not Covered]
• [Brand Preferred]	[Minimum][Maximum][[Copay [($0 - $6,000)][deductible] [coinsurance] [Not Covered]
• [Brand Non-Preferred]	[Minimum][Maximum][[Copay [($0 - $9,000)][deductible] [coinsurance] [Not Covered]
	[Refer to the Outpatient Prescription Drug Benefit in the Certificate for coverages and exclusions to prescription coverage.]
[Retail]	**[[30-90] day supply]**
[Tier 1]	[Minimum][Maximum][[Copay [($0 - $200)][deductible] [coinsurance] [Not Covered]
[Tier 2]	[Minimum][Maximum][[Copay [($0 - $300)][deductible] [coinsurance] [Not Covered]
[Tier 3]	[Minimum][Maximum][[Copay [($0 - $400)][deductible] [coinsurance] [Not Covered]
[Tier 4]	[Minimum][Maximum][[Copay [($0 - $500)][deductible] [coinsurance] [Not Covered]
[Tier 5]	[Minimum][Maximum][[Copay [($0 - $1,000)][deductible] [coinsurance] [Not Covered]
	[Refer to the Outpatient Prescription Drug

	Benefit in the Certificate for coverages and exclusions to prescription coverage.]
-	
[Mail Order]	**[[90-100] day supply]**
- [Tier 1]	[Minimum][Maximum][[Copay [($0 - $600)][deductible] [coinsurance] [Not Covered]
- [Tier 2]	[Minimum][Maximum][[Copay [($0 - $900)][deductible] [coinsurance] [Not Covered]
- [Tier 3]	[Minimum][Maximum][[Copay [($0 - $1,200)][deductible] [coinsurance] [Not Covered]
- [Tier 4]	[Minimum][Maximum][[Copay [($0 - $1,500)][deductible] [coinsurance] [Not Covered]
- [Tier 5]	[Minimum][Maximum][[Copay [($0 - $3,000)][deductible] [coinsurance] [Not Covered]
	[Refer to the Outpatient Prescription Drug Benefit in the Certificate for coverages and exclusions to prescription coverage.]

[* Benefits marked with an asterisk (*) are not subject to the [Calendar][Plan] Year Deductible.]

[(1)] Copays do not count toward the [Calendar][Plan] Year deductible.]

[(2)] [Deductible does [not] apply to OOP maximum.]

[(3)] [Co-pay does [not] apply to OOP maximum.]

[Requires Pre-Authorization. There is a penalty of [$0-10,000] for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward a deductible or out-of-pocket maximum amounts]

[[Requires Pre-Authorization.
In-Network:
There is a penalty of [$0 – $5000] for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward a deductible or out-of-pocket maximum amounts.]]
Out-of-Network
There is a penalty of [$0 – $10,000] for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward a deductible or out-of-pocket maximum amounts.]]
[Serious Mental Illness diagnoses include; Schizophrenia, Schizoaffective Disorder, Pervasive Developmental Disorder or Autism, Obsessive-Compulsive Disorder, Panic Disorder, Major Depressive Disorder, Anorexia Nervosa and Bulimia Nervosa, Additionally, coverage includes Severe Emotional Disturbances of Children (SED).]

[The following are subject to Pre-Authorization prior to obtaining services:]

[Cardiac and Pulmonary Rehabilitation
Durable Medical Equipment
Hearing Aids
Home Health Care
Hospice Care
Fertility Services
Injectable & Specialty Drugs (does not include Insulin or Anaphylatic kits)
Inpatient Admissions

Inpatient Rehabilitation
Mental Health Conditions
Maternity Inpatient Days Beyond (2-4)
Occupational Therapy
Organ Transplant
Orthotics
Outpatient Angiographic Procedures
Outpatient MRI (Including CT and PET scans)
Outpatient Nuclear Imaging
Outpatient Surgery
Pain Management/Pain Clinic Services
Physical Therapy
Prosthetics
Same Day Surgery
Skilled Nursing Care
Speech Therapy
Substance Use Disorders]

EMPLOYER GROUP APPLICATION

(Becomes part of the Group Policy)

[Product Logo]

Underwritten by: STERLING LIFE INSURANCE COMPANY
[Bellingham, WA 98227-5348]
[Third Party Administrator: Meritain
1405 Xenium Lane North, Suite 140, Minneapolis, MN 55441
(xxx) xxx-xxxx or (xxx) xxx-xxxx **Fax Enrollment/Change Form to: (xxx) xxx-xxxx**
Visit our website for more information at:]

COMPANY NAME	GROUP NUMBER (office use)
STREET ADDRESS (physical address only)	DIVISION NAME AND NUMBER (office use)
CITY STATE ZIP	REQUESTED EFFECTIVE DATE– [First of the Month][Fifteen of the Month]
BILLING/MAILING ADDRESS	COUNTY / FEDERAL EMPLOYER I.D. NUMBER
CITY STATE ZIP	TYPE OF INDUSTRY
CHIEF EXECUTIVE OFFICER OR PROPRIETOR	YEARS IN BUSINESS
BENEFITS ADMINISTRATOR / TITLE	PHONE / FAX
E-MAIL AND WEBSITE ADDRESS	OTHER LANGUAGE CONSIDERATIONS

DOES THE APPLICANT OFFER OTHER COVERAGE: ☐ YES ☐ NO
IF YES, PLEASE LIST THE CARRIERS AND TYPE OF COVERAGE OFFERED AND PREMIUM FOR EACH OPTION

1.	3.
2.	4.
PREVIOUS CARRIER(S) 1.	2.

Are all employees eligible for this plan covered by Worker's Compensation? ☐ YES ☐ NO

If NO, please explain: _____

Are your benefits subject to ERISA regulation? ☐ Yes ☐ No

TYPE OF ORGANIZATION:

☐ [Sole Proprietorship] ☐ [Corporation] ☐ [Partnership] [Other_____]

ELIGIBLE EMPLOYEES:

1. Total number of employees _____
2. Total number of employees covered under another employer sponsored plan _____
3. Number of part-time, seasonal and temporary employees _____
4. Number of eligible employees (subtract line 2 and3 from line 1) _____
5. Number of employees declining (complete waiver) or covered elsewhere _____
6. Total employees enrolling with Sterling Life Insurance Company (subtract line 5 from line 4) _____

[PPO ELIGIBLE CLASS OF EMPLOYEES:
☐ Out of Area
☐ Management Carve-out]

CONTINUATION COVERAGE:

Employer is responsible to contact current carrier to obtain name(s) and address(es) of current COBRA participants.

Please indicate number of current COBRA participants _____ (attach list)

Is employer required to offer: ☐ Federal COBRA ☐ Cal-COBRA

BENEFITS:

[PPO Medical Plans
☐ Plan] [_____]
[☐Hardware Vision Option _____]
[☐Fertility Option _____]
[☐Acupuncture]
[☐Autism Spectrum Disorder]
[☐Preventive Care Services]
[☐TMJ]
[☐Manipulative Services]
[☐ Mental Health Conditions]
☐Serious Mental Illness
☐Chemical Dependency

☐

PPO NETWORK SELECTED:

_____

[Preferred Provider Choices
State _____
PPO Network _____]
PPO Network _____]
PPO Network _____]
PPO Network _____]
PPO Network _____]
PPO Network _____]

RATES (office use):	**MEDICAL**	**EMPLOYEE**	**EE + SP/1**	**EE + CH(REN)**	**EE + SP + CH(REN)**

[Option Option Option Option]	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
[Prescription Drug Benefit]	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

EFFECTIVE/RENEWAL DATE _____ RAF:
_____ OPEN ENROLLMENT:
_____ TO:_____

Enrollment / Premium Provisions

GROUP NAME	GROUP NUMBER (office use)

SELECTED ELIGIBILITY REQUIREMENTS: A bona-fide employee/employer relationship is required to be maintained; that is the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g. FICA, FUI, SUI, and Worker's Compensation) normally associated with a bona-fide employer/employee relationship.

Eligible employees shall be active, full-time employees who usually work at least ___[20-40]_____ hours per week.

CATEGORIES OF ELIGIBILITY:

☐ **Dependents** [spouse, children] [☐Other Dependents ☐ Domestic Partner]

☐ **Retired Beneficiaries** (subject to approval) **[**☐ **Early Retirees** (under age 65)**] [**☐ **Board of Directors]**[☐**Other** – provided detailed description **]**

COMMENCEMENT OF COVERAGE:

☐ 1st month following Date of Hire☐15th month following Date of Hire

☐ 1st month following _____ days/months from Date of Hire☐15th month following Date of Hire

☐ Other (attach description)

Note: All terminations are effective the last day of the month in which Employee ceases to be eligible under group eligibility provisions.

EMPLOYER CONTRIBUTION & PARTICIPATION REQUIREMENTS:

(Employer must contribute a minimum of [25-75%] of Employee only premium)

☐ **Employee Only $ _____ or _____ % of Rate**

☐ **Dependents $ _____ or _____ % of Rate**

BROKER INFORMATION:

☐ Existing Broker

☐ New Broker (must complete Carrier Appointment &Commission Agreement)

Broker Name: _____ Phone: _____

Agency: _____ Fax: _____

Broker Number: _____ E-mail: _____

Commission: ☐ Standard Scale ☐ Flat _____% ☐ Other: _____ License Number: _____

COMMENTS:

EMPLOYER STATEMENT

We wish to enroll our organization as an employer account with Sterling Life Insurance Company.
We understand the eligibility rules applicable to enrollment and understand the premium requirements.
Employee participation requirements and employer contribution have been explained and we understand that these must be maintained in order for the account to remain eligible for coverage.

PREMIUM REQUIREMENTS: Monthly premiums are due and payable in full on the first day or the fifteen (to coincide with original effective date) of each calendar month. If premiums are not received from the employer, coverage for enrollees will be terminated on the last day or the fifteen (to coincide with original effective date) of the month for which premium was received. Any other premium payment arrangements require prior approval.

To the best of our knowledge and behalf, the foregoing statements are true and complete. This application shall be the basis for the issuance of coverage under the Group Policy and shall become a part thereof. Sterling Life Insurance Company reserves the right to terminate the Group Policy or the coverage of any individual Certificateholder who has made any material misrepresentation.

For Your protection, California law requires the following to appear on this form: "Any person who knowingly presents a false or fraudulent claim for payment of loss is guilty of a crime and may be subject to fines and confinement in a state prison."

_____ _____
Signature Date

_____
Print Name and Title

BROKER STATEMENT

I certify that: All the information contained in this application is correct to the best of my knowledge; the applicant is a bona-fide business establishment; participation requirements have been met; that all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer. I recommend that such coverage be offered and know of no reason why coverage should be declined.

Broker Signature _____ Date _____

Sales Approval _____ Date _____ Account Executive _____ Date _____

Sterling Life Insurance Company

[EMPLOYER NEW BUSINESS CHECKLIST

T

The following documentation should be completed and submitted to Meritain by the 5th of the month:

- ☐ Employer Group Application (to be completed by Employer)
- ☐ Enrollment forms _____ # of forms
- ☐ Copy of Rate Quote
- ☐ Employers must complete Sterling Life Insurance Company Group Underwriting Questionnaire
- ☐ Waiver forms must be completed for eligible employees who refuse coverage for themselves *or* their dependents
- ☐ The selected Sterling Life Insurance Company plan is primary to Medicare for *active* employees age 65 or older (and spouses age 65 or older of active employees).
- ☐ A copy of DE6 required
- ☐ A deposit in the amount of one month's premium

Return Materials to: [

[Third Party Administrator: Meritain
1405 Xenium Lane North, Suite 140, Minneapolis, MN 55441

(XXX) XXX-XXXX Phone
(XXX) XXX-XXXX Fax]
www.meritainhealth.com]]

STATEMENT OF VARIABILITY

All state mandated benefits within text that is bracketed would not be changed below that which is mandated by the state.

All text within brackets is variable as follows:

POLICY

Insurance Company address – will be verified and included, will be either a street address or PO Box.

Group Policy Number – group policy number will be included

Policyholder – name of group policyholder will be included

Date of Issue – the date of issue of the policy will be included

Renewal Premium Are Due Monthly – the renewal date will be included

State of Delivery – the state of delivery will be included

Secretary and President's signatures will be included

CERTIFICATE

Secretary and President's signatures will be included

Part 1 – Definitions:

Coinsurance/Coinsurance Percentage – [Copays and] – will be included if a Copay plan is selected. If not selected this text will not appear

Coinsurance Limit – [Copays and the] – will be included if a Copay plan is selected. If not selected this text will not appear

Deductible – [other than Copays] – will be included if a Copay plan is selected. If not selected this text will not appear

Eligible Employee - [the required number of hours as defined by the Master Application] [on a full-time basis as defined by the Master Application] The term does not include an Employee who:
[1.] [works on a part-time, temporary, seasonal, or substitute basis;]

An Employee also is a [Retiree] [tribal member] [officer][partner][or [director] as designated by the Employer in the Master application and approved by Us.

[EMBEDDED FAMILY DEDUCTIBLE means your plan contains two provisions, an Individual Deductible and a Family Deductible. This allows each family member to receive medical expenses covered at the earlier of the Individual's satisfaction of the Individual Deductible (for that individual only), or collectively when the all Family member's combined Deductible satisfy the Family Deductible (for all family members).] – will appear if selected by policyholder

[EMBEDDED FAMILY OUT-OF-POCKET MAXIMUM means your plan contains two provisions, an Individual Out-of-Pocket and a Family Out-of-Pocket Maximum. This allows each family member to receive medical expenses covered at the earlier of the Individual's satisfaction of the Individual Deductible (for that individual only), or collectively when all Family member's combined Out-of-Pocket Maximum

satisfy the Family Out-of-Pocket Maximum (for all family members).] - will appear if selected by policyholder

[ESSENTIAL HEALTH BENEFITS has the same meaning as found in section 1302(b) of the federal health care reform's Patient Protection and Affordable Care Act including any amendments, regulations, rules or other guidance issues with respect to the Act.] - will appear if non grandfathered plan.

PART 3 - EFFECTIVE DATE OF INSURANCE

[subject to receipt of the Enrollment Form by Us][the first day next following the end of any applicable Service Waiting Period][the first day of the Initial Enrollment Period] [the first day of the Special Enrollment Period]. [the first day or the fifteenth day of the month next following the later of the end of any applicable Service Waiting Period or [receipt of the Enrollment Form by Us].] – one of the above will appear depending on option chosen by the group policyholder

[the date the Dependent qualifies as a Dependent][or the first or fifteenth day of the month next following the date on which We receive the Enrollment Form]. One or the other will appear depending on what option chosen by the group policyholder

Part 4 – Medical Management:
[Pre-Authorization Program] – will be included or not included
[Pre-Authorization of Non-Emergency Inpatient Services] – will be included or not included
[Pre-Authorization of Emergency Inpatient Care] – will be included or not included
[Pre-Authorization of Pregnancy] – will be included or not included
[Pre-Authorization of Other Non Emergency Medical Care or Health Care Services] – will be included or not included. If included some or all of the following will be included or not included:

Part 6 – Covered Charges:
Item 2 Surgical Services, sub-item B – [20-40%]

Item 5 - [–] [Minor] will or will not appear

Item 6 - [–] [Major] will or will not appear

Item 16 - [Benefits for a newborn while in the Hospital are payable only under the mother's coverage.] – will appear or not appear

[The newborn establishes a claim as an individual Dependent.] – will appear or not appear

Item 26 - [Preventive Care Services must be received from an In-Network Provider or benefits will be denied.] will appear or not appear

Part 7 – Exclusions and Limitations:

The Exclusions and Limitations – will appear or not appear depending on the benefits chosen by the group policyholder

Item 20 – Hearing Expenses – [beyond the benefit limits stated in Part 6 – Covered Changes and the Schedule of Benefits] – this will be included or not included. If the Hearing and Screening Services benefit is selected, this text will be included. If the Hearing and Screening Services benefit is not selected, this text will not be included.

Item 25 – Infertility – [except as indicated in the Schedule of Benefits] – this will be included or not included. If the Infertility benefit is selected, this text will be included. If the Infertility benefit is not selected, this text will not be included.

PART 10 TERMINATION AND RENEWABILITY

[last] will appear or not appear

[Retiree][Part-time Employee][tribal member][officer][partner][or [director] of which the [Retiree] [Part-time Employee] [tribal member] [officer][partner]or [director] is a member. - will appear or not appear depending on the employer.

SERFF Tracking Number:	*ICCI-127129270*	*State:*	*California*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*PF-2011-01107*
Company Tracking Number:	*STERLING SMALL GROUP MAJOR MEDICAL PLAN*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*Sterling Small Group Major Medical Plan*		
Project Name/Number:	*Sterling Small Group Major Medical Plan/ Sterling Small Group Major Medical Plan*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
	Rate filing spreadsheet	SLIC SGPOL 511	New		CA RateFileSheet - Sterling New Product Rates 8-18-2011.pdf

	A	B	C	D	E	F	G
1	**California Rate Filing Spreadsheet - for New Product Rate Filing**						
2	Company Name: Sterling Life Insurance Company						
3	Company ID number for this filing: PF-2011-01107						
4	SERFF ID number for this filing: ICCI-127129270						
5	**Policy Form Number**	**Product Name**	**Period for which rates are to be effective**	**Rating Cell**		**Proposed Annual Premium Rates**	**Comments**
6				**Age Range**	**Type of Contract**		
7		Sterling Small Group Major Medical Plan	7/1/2011	0-29	Employee	$3,338.15	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
8		Sterling Small Group Major Medical Plan	7/1/2011	30-39	Employee	$3,843.60	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
9		Sterling Small Group Major Medical Plan	7/1/2011	40-49	Employee	$4,933.40	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
10		Sterling Small Group Major Medical Plan	7/1/2011	50-54	Employee	$6,366.41	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
11		Sterling Small Group Major Medical Plan	7/1/2011	55-59	Employee	$7,935.98	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
12		Sterling Small Group Major Medical Plan	7/1/2011	60-64	Employee	$10,057.28	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
13		Sterling Small Group Major Medical Plan	7/1/2011	65+ Medicare Secondary	Employee	$12,537.77	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
14		Sterling Small Group Major Medical Plan	7/1/2011	65+ Medicare Primary	Employee	$4,388.22	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
15		Sterling Small Group Major Medical Plan	7/1/2011	0-29	Employee plus Child(ren)	$9,103.22	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
16		Sterling Small Group Major Medical Plan	7/1/2011	30-39	Employee plus Child(ren)	$10,343.21	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
17		Sterling Small Group Major Medical Plan	7/1/2011	40-49	Employee plus Child(ren)	$11,028.77	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
18		Sterling Small Group Major Medical Plan	7/1/2011	50-54	Employee plus Child(ren)	$13,111.71	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
19		Sterling Small Group Major Medical Plan	7/1/2011	55-59	Employee plus Child(ren)	$16,752.48	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
20		Sterling Small Group Major Medical Plan	7/1/2011	60-64	Employee plus Child(ren)	$18,997.66	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
21		Sterling Small Group Major Medical Plan	7/1/2011	65+ Medicare Secondary	Employee plus Child(ren)	$25,659.58	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
22		Sterling Small Group Major Medical Plan	7/1/2011	65+ Medicare Primary	Employee plus Child(ren)	$8,980.85	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.

	A	B	C	D	E	F	G
23		Sterling Small Group Major Medical Plan	7/1/2011	0-29	Employee plus Spouse	$9,250.26	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
24		Sterling Small Group Major Medical Plan	7/1/2011	30-39	Employee plus Spouse	$9,599.25	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
25		Sterling Small Group Major Medical Plan	7/1/2011	40-49	Employee plus Spouse	$9,745.98	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
26		Sterling Small Group Major Medical Plan	7/1/2011	50-54	Employee plus Spouse	$10,770.21	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
27		Sterling Small Group Major Medical Plan	7/1/2011	55-59	Employee plus Spouse	$12,180.58	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
28		Sterling Small Group Major Medical Plan	7/1/2011	60-64	Employee plus Spouse	$13,341.64	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
29		Sterling Small Group Major Medical Plan	7/1/2011	65+ Medicare Secondary	Employee plus Spouse	$17,231.51	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
30		Sterling Small Group Major Medical Plan	7/1/2011	65+ Medicare Primary	Employee plus Spouse	$6,031.03	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
31		Sterling Small Group Major Medical Plan	7/1/2011	0-29	Family	$13,182.75	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
32		Sterling Small Group Major Medical Plan	7/1/2011	30-39	Family	$14,614.57	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
33		Sterling Small Group Major Medical Plan	7/1/2011	40-49	Family	$14,888.70	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
34		Sterling Small Group Major Medical Plan	7/1/2011	50-54	Family	$17,227.92	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
35		Sterling Small Group Major Medical Plan	7/1/2011	55-59	Family	$18,823.94	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
36		Sterling Small Group Major Medical Plan	7/1/2011	60-64	Family	$21,751.74	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
37		Sterling Small Group Major Medical Plan	7/1/2011	65+ Medicare Secondary	Family	$28,394.37	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.
38		Sterling Small Group Major Medical Plan	7/1/2011	65+ Medicare Primary	Family	$9,938.03	Rate for Bakersfield, CA, Plan 1 with Rx Option 7. Actuarial memorandum includes adjustment factors for other plans and rating areas.

SERFF Tracking Number:	*ICCI-127129270*	*State:*	*California*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*PF-2011-01107*
Company Tracking Number:	*STERLING SMALL GROUP MAJOR MEDICAL PLAN*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*Sterling Small Group Major Medical Plan*		
Project Name/Number:	*Sterling Small Group Major Medical Plan/ Sterling Small Group Major Medical Plan*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Filing Cover Sheet
Comments:
Attachment:
CA SLIC SG filing cover letter.pdf

Item Status: **Status Date:**

Satisfied - Item: Document Submission Formset
Comments:
Attachment:
CA SLIC SG Document formset.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability: submit as a form under "form schedule" tab.
Comments:
see form schedule tab

Item Status: **Status Date:**

Bypassed - Item: Provider Network Report
Bypass Reason: na
Comments:

Item Status: **Status Date:**

Satisfied - Item: Health Policy Component Location List
Comments:

see

Attachment:

CA SLIC SG Component list.pdf

Item Status: **Status Date:**

Satisfied - Item: Third Party Authorization

Comments:

Attachment:

SLIC Authorization Letter.pdf

Item Status: **Status Date:**

Bypassed - Item: Explanation of Deviation from Compulsory Uniform Provisions

Bypass Reason: NA

Comments:

Item Status: **Status Date:**

Bypassed - Item: PPACA Uniform Compliance Summary

Bypass Reason: NA

Comments:

Item Status: **Status Date:**

Satisfied - Item: Actuarial Memorandum and Rates

Comments:

Attachment:

07212011 CA Small Employer Group PPO Products Final.pdf

Item Status: **Status Date:**

Satisfied - Item: New Product Information document

SERFF Tracking Number:	*ICCI-127129270*	*State:*	*California*
Filing Company:	*Sterling Life Insurance Company*	*State Tracking Number:*	*PF-2011-01107*
Company Tracking Number:	*STERLING SMALL GROUP MAJOR MEDICAL PLAN*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.003A Small Group Only - PPO*
Product Name:	*Sterling Small Group Major Medical Plan*		
Project Name/Number:	*Sterling Small Group Major Medical Plan/ Sterling Small Group Major Medical Plan*		

Comments:

Attachment:

CA SLIC SG NewProdRtFmv2 - Sterling SG 8-18-2011.pdf

CALIFORNIA DEPARTMENT OF INSURANCE

Reset Form

FILING COVER SHEET
for
FORMS FILINGS with the POLICY APPROVAL BUREAU

(Suggested for use as the cover letter required by Title 10, California Code of Regulations §2205.)

TO: State of California Department of Insurance Policy Approval Bureau 45 Fremont Street San Francisco, CA 94105	FROM: (Official Insurer Name): Sterling Life Insurance Company Submitter and Complete Mailing Address: Brenda Dawson, 3925 East State Street, Suite 200, Rockford, IL 61108 Submission Date: 5/31/11

1. IDENTIFYING FORM NUMBER(S): SLIC SG POL 511
[The form number(s) of one or more of the documents submitted by which the filing can be identified. §2205(a)]

2. DOCUMENT CLASS [The subdivision of 10 CCR §2202(a) which best describes the forms submitted. (§2205(b)]

Generic Description and Definition Citation	Check Below	Generic Description and Definition Citation	Check Below
Health Insurance [Hospital, medical, surgical insurance, expense-incurred or indemnity.§2202(a)(1)]		Credit Life and Disability [§2202(a)(6)]	
Group and Blanket Life and Non-health Disability [(§ɔ2202(a)(2)]		Supplemental Life Benefits [§2202(a)(7)]	
Individual Disability, Non-health [ɔ2202(a)(3)]		Variable Life and Annuities [§2202(a)(8)]	
Medicare Supplement [§ɔ2202(a)(4)]		Fraternals [Non-health Disability. §2202(a)(9)]	
Long-Term Care [§2202(a)(5)]		Unclassified [§2202(a)(11)]	

* Describe briefly (documents other than those described above may have to be filed with other Department Bureaus; see §2206):
Small Group Major Medical Policy, Certificate, Schedule Page, Amendatory Endorsement

3. GROUP AND/OR INDIVIDUAL [Are the forms group, individual or used in both contexts? §2205(b)]

Group Only:	✔	Individual Only:		Group and Individual:	

4. EMPLOYER SIZE (Employer Health Insurance Only) [Where the forms submitted provide health coverage through employment, the minimum and the maximum sizes of the employers in terms of number of employees §2205(c)]

2 to 50 Employees:	✔	Over 50 Employees:		All Employers:	

5.REPLACES PREVIOUSLY-APPROVED DOCUMENT(S)? [Do any documents replace previously-approved documents.§2205(d)]

6. FINAL PRINT FORM? [List those documents NOT in the final printed form in which they will be issued to insureds §2205(e)]

Document(s)	Document(s)

7. TYPE OF DOCUMENT WITH WHICH IT WILL BE USED [For each document (such as a rider) which is designed to be used with another document not included in the filing, a statement of the document class with which it is to be used. §2205(f)]

Document Form Number	Document Class (from Item 2, above)

8. Master Policy Form Number and Approval Date:_____
[Where a certificate is submitted for use with a previously approved "group" document, the form number and the filing or approval date of the previously approved group document. §2205(g)]

9. IF ABOVE INFORMATION CANNOT BE FURNISHED, EXPLAIN WHY. [If the submitter is unable to furnish the information requested above, explain why. §2205(h)]

This is a new filing.

10. REMARKS AND ADDITIONAL INFORMATION (Attach additional sheets if necessary):

SUBMITTER'S SIGNATURE AND TITLE: Brenda Dawson Digitally signed by Brenda Dawson DN: CN = Brenda Dawson, C = US Date: 2011.05.31 13:04:42 -05'00'

CALIFORNIA DOCUMENT SUBMISSION FORMSET

Reset Form

California Insurer Number:
(NOT NAIC Number)

FOR DEPARTMENT USE ONLY

Official Insurer Name:

Sterling Life Insurance Company

Our File #

Fee Code:

Reviewer:

Submitter and Complete Mailing Address:

Brenda Dawson
3925 East State Street, Suite 200
Rockford, IL 61108

Submission Date: 05/31/2011

Dept Action Date:

	Document Form Number	Doc Type ("Policy," etc)	Document Coverage	Department Action	Fee
1	SLIC SGPOL 511	Policy			
2	SLIC SG CER CA 511	Certificate			
3	SLIC NOTCA 511	Notice			
4	SLIC SGSCH CA 511	Schedule			
5	SLIC SGER APP CA 511	Group Application			
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					

INSTRUCTIONS: Complete the part of the form to the left of the double vertical line. Enter one document to a numbered line. Use additional formsets if necessary. Be accurate - the copy of this form that we return to you will be your only record of our action on your submission.

THIS IS NOT A BILL - DO NOT PAY. YOU WILL RECEIVE A SEPARATE FILING FEE INVOICE SHORTLY; REMIT FEES ONLY WITH THAT INVOICE.

Total $

Cont'd on __ pages

DSF 1.35

#514705v1

Health Policy Component Location List

To help speed review of your policy, please identify where in your policy each component can be found.

Reset Form

Mandated Benefits

Location in Policy	*Mandated Benefit*	*Location in Policy*	*Mandated Benefit*	*Location in Policy*	*Mandated Benefit*
C-13	10119(b): coverage, **newborn** infant and adoptive child.	C-8	10123.68: **second opinion**	C-29	10123.141: **special footwear for foot disfigurement**
C-5, 12,23	10119.5 **complications of pregnancy** [if maternity is covered]	C-28	10123.81: **mammograms**	C-23	10123.184: **Expanded Alpha Feto Protein (AFP) prenatal testing program.** (if maternity benefit provided)
confirm not excluded/ limited	10119.7: **diethylstilbestrol (DES)** conditions or exposure: Cannot exclude coverage	C-28	10123.82: **post-laryngectomy prosthetic devices**	C-29	10123.185: **osteoporosis**.
C-23	10119.9: **general anesthesia for dental procedures** for certain patients	C-28	10123.83: **prostate cancer screening/diagnosis**	C-8	10123.195: **off-label drug use**
C-28	10123.5: **preventive care for children**	C-21	10123.86(a)(1): **Mastectomy** Length of stay	C-25	10123.196: **prescription contraceptive methods .** if outpatient drugs covered
C-21	10123.8: **breast cancer screening, diagnosis and treatment**, including prosthetic devices and reconstructive surgery	C-21	10123.86(a)(2): Mastectomy, Prostheses & reconstructive surgery (see also 10123.8)	C-4	10126.6: **emergency medical transportation services**
C-21	10123.16: certain degenerative illnesses, including **Alzheimer's disease**.	C-21	10123.86: **complications** of mastectomy, lymphedema	C-10, 12	10144.5: **severe mental illnesses (adults and children) and serious emotional disturbances of children.**
C-28	10123.18: annual **cervical cancer screening test**	C-22	10123.87(b)(1): **Maternity** length of stay: notice of coverage mandated in (a) [if maternity is covered]	C-29	10145.2: **AIDS vaccine**.
C-28	10123.20: **cancer screening tests**	C-29	10123.88. **reconstructive surgery**	C-29	10145.4: **cancer clinical trials.**
C-27	10123.21: surgical procedures for **jawbone conditions (TMJ)**.	C-28	10123.89: **phenylketonuria (PKU).**	C-22	10176.61: **diabetes**.

Mandated Offers

Location in Policy	*Mandated Offer*	*Location in Policy*	*Mandated Offer*	*Location in Policy*	*Mandated Offer*
C-27	10119.6: **infertility treatment**.	C-30	10123.7: **orthotic and prosthetic devices**.	C-28	10123.55: **preventive care of children** ages 17 and 18
C-30	10119.8: **blood lead levels for children**.	C-29	10123.9: **prenatal diagnosis of genetic disorders** if maternity coverage is present.	C-29	10123.141: **special footwear** related to foot disfigurement.
C-6	10121.7: **domestic partner coverage**	C-24	10123.10: **home health care**.	C-23	10125: **mental and nervous disorders**.
C-37	10122.1: **physically handicapped** members	C-12	10123.15: specified biologically based **severe mental disorders**.	C-26	10127.3: **acupuncture**.
C-13	10123.6: **alcoholism**.			C-21	10176.6: **diabetic daycare self-management education programs**.

Compulsory Uniform Provisions (individual/group)

38	**IC 10350.1 / 10 CCR sec. 2232.17 Entire contract and changes**	39	**10350.5 / 2232.21 Notice of claim**	39	**10350.9 / 2232.25 Payment of claims**
38	**10350.2 / 2232.18.. Time limit on certain defenses and incontestability**	39	**10350.6 / 2232.22 Claim forms**	39	**10350.10 / 2232.26 Physical examinations and autopsy**
35	**10350.3. / 2232.19 Grace period**	39	**10350.7 / 2232.23. Proofs of loss**	40	**10350.11. / 2232.27 Legal actions**
NA	**10350.4. / 2232.20 Reinstatement**	39	**10350.8. / 2232.24 Time of payment of claim**	na	**10350.12. / 2232.28 Change of beneficiary**

Other Components

32	10133.56 **Continuity of Care** completion of coverage for terminated provider (PPO) (also 10133.55(a)(2))		10273.6: Guaranteed-renewable for *individual* plans		10133: assignment of benefits for group insurance
32	10270.98 **Coordination of benefits** (group)	37	12672 **Conversion**	39	10123.147: payment of **claims**
32	10119.1 **transfer** between *individual* plans	37	10145.3 Experimental treatment/ independent med. review		
			10169: **IMR**		

STERLING Life Insurance Company

Real People. Wise Choices.®

April 19, 2011

Mr. Brian Camling
President
Insurance Compliance Consultants, Inc.
3925 East State Street, Suite 200
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc., has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of Sterling Life Insurance Company regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Sterling Life Insurance Company may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

Craig Bodway
Vice President
Compliance and Regulatory Affairs

2219 Rimland Drive ▪ P.O. Box 5348, Bellingham, WA 98227-5348
Toll-Free: 1-888-858-8546 ▪ Fax: 360-647-8632 ▪ www.sterlingplans.com

12125 Technology Drive
Eden Prairie, MN 55344
T 888-445-8745
F 952-942-3201
www.optum.com

ACTUARIAL MEMORANDUM

Date: July 21, 2011

To: Sterling Life Insurance Company

From: OptumInsight

RE: STERLING LIFE INSURANCE COMPANY
PPO RATE FILING EFFECTIVE JULY 1, 2011 - SMALL GROUP EMPLOYERS

Sterling Life Insurance Company ("Sterling") has requested OptumInsight ("Optum") to develop manual premium rates for its preferred provider organization ("PPO") small employer group product portfolio. This memorandum describes the scope, target market, development of claim costs, variables that impact claim costs, the development of the premium rates and target loss ratios.

SCOPE OF MEMORANDUM

The purpose of this memorandum is to serve as the filing and request for approval of the PPO premium rates for small employer groups enrolling on or after July 1, 2011.

PRODUCT DESCRIPTION

The PPO product is for small employer groups who are domiciled in the State of California and select a State-licensed HMO or insurance company ("carrier") to provide health benefits for its eligible employees residing in the carrier's service area and who may also have employees residing outside the carrier-approved service area. The PPO products will provide health benefits to the eligible employees and dependents who reside outside the carrier's service area.

NETWORK

The PPO product uses the network developed and maintained by a national PPO network vendor. Out-of-area ("OOA") eligible employees and dependents who reside in the PPO network service area will receive a PPO benefit as selected by the small employer group.

DESCRIPTION OF BENEFITS

The filed PPO product schedule of benefits documents the benefits available to small employer groups. The PPO products provide comprehensive coverage for inpatient, outpatient, physician and prescription drug services. Brief descriptions of the nine PPO products in Sterling's PPO product portfolio are contained In Exhibit A attached to this memorandum. The nine PPO products displayed in this exhibit reflect only a sampling of the range of products offered in California.

CLAIM COST DEVELOPMENT

The manual PPO claim costs were developed by Optum using Optum's proprietary health care claim databases. Optum created a methodology for developing locality-specific rates that incorporate detailed data from contributors (HMOs, PPOs, insurance companies and other managed care organizations) and comparative data from a broad array of sources (various public use datasets, including various state discharge databases, the HCUP database, the Medicare MEDPAR database, and other resources).

Actuarial and clinical judgment was applied during the development of these rates in order to produce reasonable results. The data is intended to represent Optum's best actuarial estimate of potential claim cost in a specific area given the historical aggregate cost levels vis-à-vis nationwide rates. The claim experience is updated annually. The current database represents the claims experience of over five million members for the period January 1, 2008 through December 31, 2008. Claim cost projections appropriate for a July 1, 2011 effective date were developed by trending current claim experience using historical and projected medical claim cost trends from the Optum databases.

Optum's projected claim costs reflect variations in utilization and billed unit costs by metropolitan statistical area ("MSA"). Optum uses the U.S. Census Bureau definition of MSAs, which allows us to map these costs into three-digit ZIP codes. Optum has smoothed the experience for certain ZIP codes that are considered to be outliers. Furthermore, we have extrapolated or interpolated the experience of credible geographic areas for areas that lacked credible experience.

In geographic areas where the national PPO vendor has a PPO network, PPO contractual discounts are incorporated into the in-network pricing component. Under the current arrangement, the national PPO vendor charges an access fee for the use of its networks. The access fee is not considered a claim cost, but rather an administrative cost and is incorporated into the retention expense.

Exhibit B provides the PPO expected allowed average claim costs, expressed as a per member per month ("PMPM") dollar amount, for each of the PPO products by three-digit ZIP codes for five geographic regions in California. The in-network column represents the expected PPO in-network utilization and the expected average allowed unit cost after consideration of the PPO provider discounts. The out-of-network column represents the

expected PPO out-of-network utilization and the expected average allowed unit cost with no provider discounts.

The allowed average costs contained in Exhibit B are before member cost sharing. To adjust the allowed PMPM to a net PMPM (i.e., after member cost sharing), actuarial continuance tables were developed to properly reflect member co-payments, deductibles, coinsurance and co-insurance maximum out-of-pocket cost sharing provisions. The actuarial continuance tables reflect the geographic differences in allowed costs by geographic area.

From the actuarial continuance tables, benefit factors are developed which are applied to the allowed claim costs in order to develop the expected claim cost after member cost sharing (i.e., net claim cost PMPM). Please refer to Exhibit C for an illustration of benefit factors for the plans referenced in this filing.

ADJUSTMENT TO NET CLAIMS COSTS

The net claims costs are adjusted to reflect the age-gender composition of the employees of the small employer group through the application of age-gender cohort morbidity factors. For effective dates other than July 1, 2011, the average allowed costs are trended forward based on a 6.6% annual in-network average trend and a 6.8% annual out-of-network average trend.

Finally, the composite PPO product net claim cost PMPM is developed by weighting the in-network and out-of-network net claim costs estimates.

RETENTION EXPENSE

A retention load is added to the PPO net claim cost to obtain the required revenue PMPM rate. Retention expenses are expenses associated with marketing, enrollment, billing, claims adjudication, medical management, network management, profit, taxes and other administrative and operational functions.

The retention expense assumed in this filing is 20% of premium.

ANTICIPATED LOSS RATIO

The anticipated loss ratio for this product is expected to be 80%.

PREMIUM RATE DEVELOPMENT

Attached to this actuarial memorandum are five exhibits. Exhibit A provides the PPO plan designs. Exhibit B displays the expected claims costs for both In-Network and Out-of-Network services. Exhibit D provides the per contract factors that are used to calculate the tabular rate output. Please refer to Exhibit E for an example of how all of these factors are used to calculate the rate for a group. The plans chosen to illustrate the premium rate development are Medical Plan 1 and Rx Plan 7 and the rating region is Bakersfield. The steps in the premium rate development are documented below.

- Step 1 – Choose benefit plan and rating region for which premium rates are to be developed. In this premium rate development illustration, we chose Medical Plan 1 and Rx Plan 7 and the Bakersfield rating region. The expected allowed amounts from Exhibit B are as follows:

  - In-Network Medical - $273.98
  - Out-of-Network Medical - $591.57
  - Rx - $58.44

- Step 2 – Weight the resulting net claims costs for the in-network and out-of-network medical expenses by anticipated distribution of services by provider delivery system (i.e., in-network or out-of-network).

- Step 3 – Apply the benefit factors to translate the expected allowed PMPM amounts to the Medical Plan 1 and Rx Plan 7 benefit costs. The expected allowed amounts are prior to any benefit cost sharing provisions. The resulting medical expense amount after application of the benefit factor represents the expected medical expense for the selected benefit plan after the application of the benefit cost sharing provisions summarized in Exhibit A.

- Step 4 – Apply the Risk Adjustment factor, which can vary from 0.900 to 1.100. For this illustration a factor of 1.000 was used.

- Step 5 – Add the retention load to expected net claims cost to arrive at a final premium about per member.

- Step 6 – Apply the average members per employee factor to the Premium PMPM to have an average premium per employee per month (PEPM)

- Step 7 – Multiple the average PEPM by the contract factors to arrive at a full output of rates for a group.

ACTUARIAL OPINION

OptumInsight has prepared this memorandum and its supporting exhibits for purposes of filing Sterling Life Insurance Company's PPO product premium rates. The information contained in this report may not be appropriate for other purposes and should not be used for any other purposes without prior notification to OptumInsight. OptumInsight requests that this rate filing be treated as proprietary and confidential information.

I, David M. Tuomala, a Fellow of the Society of Actuaries, a Fellow of the Conference of Consulting Actuaries and a member of the American Academy of Actuaries, do hereby certify that in my opinion, the revenue requirements developed in accordance with the methodology described in this filing are:

- Neither inadequate, nor excessive, nor unfairly discriminatory:
- Appropriate for the classes of risk for which they are computed, and
- Computed according to methodology which is based upon consistent and equitable actuarial principles.

David M. Tuomala, FSA, FCA, MAAA
Director, Actuarial Consulting
(952) 942-3219

/Attachments

Sterling Life Insurance Company **Exhibit A.1**

California Small Employer PPO Rate Filing
PPO Plan Design

	Plan 1		Plan 2		Plan 3		Plan 4	
Benefit Plan Provisions	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Plan Deductible (1)	500	1,000	1,000	2,000	1,500	3,000	3,000	6,000
Family Deductible (2 Full Family Members)	1,000	2,000	2,000	4,000	3,000	6,000	6,000	12,000
Coinsurance	20%	50%	25%	50%	30%	50%	20%	50%
Out-of-Pocket Maximum (2)	4,000	10,000	5,000	10,000	4,500	9,000	4,500	8,000
Family Out-of-Pocket Maximum (2 Full Family Members)	8,000	20,000	10,000	20,000	9,000	18,000	8,000	16,000
Combined Lifetime Maximum Benefit	Unlimited		Unlimited		Unlimited		Unlimited	
Copayment:								
Office Visit (Non-Preventative Care)	25	NA	35	NA	50	NA	NA	NA
Inpatient Services	500/ded/20%	NA	1000/ded/25%	NA	1000/ded/30%	NA	NA	NA
Outpatient Hospital Services (Surgery) (4)	$250/ded/20%	NA	500/ded/25%	NA	500/ded/25%	NA	NA	NA
Office Surgery (4)	$250/ded/20%	NA	500/ded/25%	NA	500/ded/25%	NA	NA	NA
Emergency Room	$100/ded/+20%	$100/ded/+20%	$100/ded/+25%	$100/ded/+25%	$100/ded/+30%	$100/ded/+30%	NA	NA
Urgent Care	50	NA	70	NA	75	NA	NA	NA
Dependent Age Limit	26		26		26		26	
Student Age Limit	26		26		26		26	
PPO Product:								
Doctor Care:								
Doctor Office Visit	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Ded plus Coins	Ded plus Coins
Lab Tests & X-rays* (3)	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Doctor Office Surgery* (3)	Copay plus Coins	Ded plus Coins	Copay plus Coins	Ded plus Coins	Copay plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Adult Preventive Care:								
Annual Welness Exam	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered
Annual Pap Exam & Lab	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered
Mamography	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered
Annual Prostate Screening	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered
Children Preventive Care (Well-Child Care):								
Office Visits, Screenings & Immunizations	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered
Hospital Inpatient Services: (4)								
Semi-private Hospital Room & Board	Copay/ded/Coins	Ded plus Coins	Copay/ded/Coins	Ded plus Coins	Copay/ded/Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Physician & Surgeon Services	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Lab, X-ray & Other Facility Charges	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Hospital Outpatient Services: (4)								
Outpatient Surgery	Copay/ded/Coins	Ded plus Coins	Copay/ded/Coins	Ded plus Coins	Copay/ded/Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Other Outpatient Services	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Emergency Services:								
Emergency Room	Copay/ded/Coins	Copay/ded/Coins	Copay/ded/Coins	Copay/ded/Coins	Copay/ded/Coins	Copay/ded/Coins	Ded plus Coins	Ded plus Coins
Urgent Care	Copayment	Copayment	Copayment	Copayment	Copayment	Copayment	Ded plus Coins	Ded plus Coins
Ambulance	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Maternity Care:								
Office Visits (Pre- & Post-Natal)	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Ded plus Coins	Ded plus Coins
Lab Tests & X-rays (3)	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Semi-private Hospital Room & Board	Copay/ded/Coins	Ded plus Coins	Copay/ded/Coins	Ded plus Coins	Copay/ded/Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Labor & Delivery	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Routine Newborn Nursery Care	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Rehabilitation Services: (4)								
Inpatient	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Outpatient	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Skilled Nursing Facility: (4)								
SNF	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Home Health Care: (4)								
Home Health Care	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Durable Medical Equipment:								
Durable Medical Equipment	Ded + 50% Coins	Ded + 50% Coins	Ded + 50% Coins	Ded + 50% Coins	Ded + 50% Coins	Ded + 50% Coins	Ded + 50% Coins	Ded + 50% Coins
Chiropractic Services:								
Chiropractic Services	Ded plus Coins	Not Covered	Ded plus Coins	Not Covered	Ded plus Coins	Not Covered	Ded plus Coins	Not Covered
Chiropractic Services Annual Maximum	12 Visits		12 Visits		12 Visits		12 Visits	
Organ Transplant: (4)								
Organ Transplant Services	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Mental Health Treatment: (4) (5)								
Inpatient	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Inpatient Annual Maximum	No Limit		No Limit		No Limit		No Limit	
Outpatient	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins
Outpatient Annual Maximum	No Limit		No Limit		No Limit		No Limit	
Alcohol or Chemical Dependency Treatment: (4)								
Inpatient	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Inpatient Annual Maximum	No Limit		No Limit		No Limit		No Limit	
Outpatient	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins
Outpatient Annual Maximum	No Limit		No Limit		No Limit		No Limit	
Acupressure/Accupuncture:								
Acupressure/Accupuncture Services	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hospice Service: (4)								
Hospice Service	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Colorectal Cancer Exam								
Colorectal Cancer Exam	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered
Prescription Drug								
Retail	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options
Mail Order	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options

(1) No Deductible Carry-Forward
(2) Deductible does apply to OOP Maximum (Copays do not go to deductible)
(3) For services not provided as part of an office visit.
(4) Requires Prospective Review
(5) Severe Mental Illness and Severe Emotional Disturbance of Children (SED) is covered the same as any other illness.

California Small Employer PPO Rate Filing
PPO Plan Design

	Plan 5		Plan 6		Plan 7		Plan 8		Plan 9	
Benefit Plan Provisions	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Plan Deductible (1)	500	1,000	1,000	2,000	1,500	3,000	2,000	4,000	3,000	6,000
Family Deductible	1,000	2,000	2,000	4,000	3,000	6,000	4,000	8,000	6,000	12,000
Coinsurance	20%	50%	20%	50%	20%	50%	20%	50%	10%	30%
Out-of-Pocket Maximum (2)	2,000	4,000	4,000	8,000	6,000	12,000	5,500	10,000	5,500	11,000
Family Out-of-Pocket Maximum	4,000	8,000	8,000	16,000	12,000	24,000	11,000	20,000	11,000	22,000
Combined Lifetime Maximum Benefit	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Copayment:										
Office Visit (Non-Preventative Care)	20	NA	30	NA	40	NA	NA	NA	NA	NA
Emergency Room	$100+20%	$100+20%	$100+20%	$100+20%	$100+20%	$100+20%	20%	20%	20%	20%
Urgent Care	50		50		50					
Dependent Age Limit	26		26		26		26		26	
Student Age Limit	26		26		26		26		26	
PPO Product:										
Doctor Care:										
Doctor Office Visit	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Lab Tests & X-rays* (3)	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Doctor Office Surgery* (3)	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Adult Preventive Care:										
Annual Wellness Exam	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered
Annual Pap Exam & Lab	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered
Mamography	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered
Annual Prostate Screening	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered
Children Preventive Care (Well-Child Care):										
Office Visits, Screenings & Immunizations	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered
Hospital Inpatient Services: (4)										
Semi-private Hospital Room & Board	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Physician & Surgeon Services	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Lab, X-ray & Other Facility Charges	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Hospital Outpatient Services: (4)										
Outpatient Surgery	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Other Outpatient Services	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Emergency Services:										
Emergency Room	Copay plus Coins	Copay plus Coins	Copay plus Coins	Copay plus Coins	Copay plus Coins	Copay plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Urgent Care	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Ambulance	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Maternity Care:										
Office Visits (Pre- & Post-Natal)	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Lab Tests & X-rays (3)	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Semi-private Hospital Room & Board	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Labor & Delivery	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Routine Newborn Nursery Care	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Rehabilitation Services: (4)										
Inpatient	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Outpatient	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Outpatient Rehab Svcs Annual Maximum	60 Visits per Calendar Year		60 Visits per Calendar Year		60 Visits per Calendar Year		60 Visits per Calendar Year		60 Visits per Calendar Year	
Skilled Nursing Facility: (4)										
SNF	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
SNF Svcs Annual Maximum	100 days per Calendar Year		100 days per Calendar Year		100 days per Calendar Year		100 days per Calendar Year		100 days per Calendar Year	
Home Health Care: (4)										
Home Health Care	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Home Health Svcs Annual Maximum	100 Visits per Calendar Year		100 Visits per Calendar Year		100 Visits per Calendar Year		100 Visits per Calendar Year		100 Visits per Calendar Year	
Durable Medical Equipment:										
Durable Medical Equipment	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Chiropractic Services:										
Chiropractic Services	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Ded plus Coins	Ded plus Coins	Copayment	Ded plus Coins
Chiropractic Services Annual Maximum	12 Visits		12 Visits		12 Visits		12 Visits		12 Visits	
Organ Transplant: (4)										
Organ Transplant Services	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Mental Health Treatment: (4) (5)										
Inpatient	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Inpatient Annual Maximum	30 Days		30 Days		30 Days		30 Days		30 Days	
Outpatient	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Ded plus Coins	Ded plus Coins	Copayment	Ded plus Coins
Outpatient Annual Maximum	30 Visits (Combined w/ ACD)		30 Visits (Combined w/ ACD)		30 Visits (Combined w/ ACD)		30 Visits (Combined w/ ACD)		30 Visits (Combined w/ ACD)	
Alcohol or Chemical Dependency Treatment: (4)										
Inpatient	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Inpatient Annual Maximum	20 Days		20 Days		20 Days		20 Days		20 Days	
Outpatient	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Ded plus Coins	Ded plus Coins	Copayment	Ded plus Coins
Outpatient Annual Maximum	30 Visits (combined w/ MH)		30 Visits (combined w/ MH)		30 Visits (combined w/ MH)		30 Visits (combined w/ MH)		30 Visits (combined w/ MH)	
Acupressure/Accupuncture:										
Acupressure/Accupuncture Services	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Copayment	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Acupressure/Accupuncture Annual Maximum	$500		$500		$500		$500		$500	
Hospice Service: (4)										
Hospice Service	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins	Ded plus Coins
Colorectal Cancer Exam										
Colorectal Cancer Exam	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Not Covered	No Cost Sharing	Ded plus Coins
Prescription Drug										
Retail										
Mail Order	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay//Coins Options	Ded/Copay/Coins Options
	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options	Ded/Copay/Coins Options

(1) No Deductible Carry-Forward
(2) Deductible does not apply to OOP Maximum
(3) For services not provided as part of an office visit.
(4) Requires Prospective Review
(5) Severe Mental Iliness and Severe Emotional Disturbance of Children (SED) is covered the same as any other illness.

California Small Employer PPO Rate Filing
Expected Allowed Cost by Region

Region	Three-Digit ZIP Code	Expected Allowed Cost PMPM		
		Medical		Free Standing Rx
		In-Network	Out-of-Network	
San Diego / Riverside	919 - 921, 925	383.11	669.03	58.44
Bakersfield	931	273.98	591.57	58.44
Santa Barbara	933	380.95	627.83	58.44
San Luis Obispo	934	465.27	823.65	58.44
Out of Area	All other 3-digit zip codes in CA	342.27	739.04	58.44

Sterling Life Insurance Company

Exhibit C.1

California Small Employer PPO Rate Filing
Benefit Ratios by Plan Type

	Expected Benefit Ratio	
	Medical	
Plan Design	In-Network	Out-of-Network
Plan 1	0.795	0.711
Plan 2	0.710	0.678
Plan 3	0.668	0.659
Plan 4	0.604	0.591
Plan 5	0.822	0.783
Plan 6	0.746	0.696
Plan 7	0.662	0.635
Plan 8	0.637	0.602
Plan 9	0.616	0.579

Sterling Life Insurance Company

Exhibit C.2

California Small Employer PPO Rate Filing
Benefit Ratios by Plan Type

	In-Network (1)			Expected Benefit Ratio
	Retail	Mail Order	Rx Deductible	Free Standing Rx
Plan Design				
Rx Option 1	10.20.40	20.40.80	$0	0.809
Rx Option 2	10.30.50	20.60.100	$0	0.766
Rx Option 3	15.35.50	30.70.100	$0	0.698
Rx Option 4	20.40.60	40.80.120	$0	0.622
Rx Option 5	15.35.50	30.70.50	$150	0.606
Rx Option 6	20.40.60	40.80.120	$150	0.559
Rx Option 7	10.30.50	30.90.150	$0	0.764
Rx Option 8	10.30.50	30.60.150	$250	0.587
Rx Option 9	15.30.50	45.90.150	$500	0.491

(1) Factors assume no Out-of-Network Benefit

Sterling Life Insurance Company **Exhibit D**

California Small Employer PPO Rate Filing
Premium Development Illustration

Age Factor Table Look-ups

Age Band	Employee	Employee plus Child(ren)	Employee plus Spouse	Family
0-29	0.347	0.946	0.962	1.370
30-39	0.400	1.075	0.998	1.519
40-49	0.513	1.146	1.013	1.548
50-54	0.662	1.363	1.120	1.791
55-59	0.825	1.741	1.266	1.957
60-64	1.045	1.975	1.387	2.261
65+ Medicare Secondary	1.303	2.667	1.791	2.952
65+ Medicare Primary	0.456	0.934	0.627	1.033

California Small Employer PPO Rate Filing
Premium Development Illustration

Bakersfield - Plan 1, Rx Option 7 Rates

	Medical		Composite		Total
	In-Network	Out-of-Network	Medical	Rx	
Allowed Costs	273.98	591.57		58.44	
Weighting IN/OON	0.8500	0.1500		1.0000	
Total Allowed Cost	232.88	88.74	321.62	58.44	380.06
Benefit Factor			0.7715	0.7644	0.7704
Risk Adjustment Factor			1.0000	1.0000	1.0000
Expected Net Cost			248.14	44.67	292.82
Retention (20%)					366.02
Average Members Per Employee					2.1903
Expected Premium PEPM					801.69
Contract Factor for Employee in Age 0-29					0.3470
Expected Premium for Employee in Age 0-29					**278.18**

Complete Tab of Rates for Plan 1

	Employee	**Employee plus Child(ren)**	**Employee plus Spouse**	**Family**
0-29	$278.18	$758.60	$770.86	$1,098.56
30-39	320.30	861.93	799.94	1,217.88
40-49	411.12	919.06	812.17	1,240.72
50-54	530.53	1,092.64	897.52	1,435.66
55-59	661.33	1,396.04	1,015.05	1,568.66
60-64	838.11	1,583.14	1,111.80	1,812.64

DEPARTMENT OF INSURANCE
Legal Division
45 Fremont Street, 24th Floor
San Francisco CA 94105

California New Product Rate Filing Form

For Initial Filing of Individual and Small Group Health Insurance
New Product Rates, Version 2

(do not use this form for filings of rates for existing products)

The rate filing submission for new product rates should include:

1) This form
2) A spreadsheet with rate information responsive to Questions 10 & 15, below.

1) Company Name:

Sterling Life Insurance Company

2) Number of policy forms covered by the filing: 1

3) Policy form numbers covered by the filing:
List all of the policy form numbers covered by this filing, and all product names associated with each policy form number, in the spreadsheet submitted in response to Question 7.

4) Product types covered by the filing. Selected from the following:

○	HMO (Health Maintenance Organization)
◉	PPO (Preferred Provider Organization)
○	EPO (Exclusive Provider Organization)
○	POS (Point of Service)
○	FFS (Fee for Service)
○	Other (describe) _____

5) Segment type. One of the following:

◉	Small Group (2-50 employees)
○	Individual

Note: Large Group, Small Group, and Individual filings should not be combined within a single filing.

6) Plan/Insurer Type. One of the following: for-profit company, not-for-profit company.

◉	For-profit company
○	Not-for-profit company

7) Annual Rate

In a separate spreadsheet, for each product included in the filing, show the policy form number(s), each product name associated with each form number, the period for which the rates are to be effective, and the proposed annual premium rates for each rating cell.

8) Review category: One of the following:

○	Initial Filing for New Product
○	Filing for Existing Product
◉	Resubmission

Resubmissions should be submitted through SERFF under the same state filing number and SERFF tracking number assigned to the original submission of this filing. Do not submit resubmissions as a new filing.

9) Comments. Place any needed comments here.

#662302v1